

**EXPOSING
THE COMPLEX REALITIES
OF
NURSING
UNRESPONSIVE PATIENTS' PAIN
IN
INTENSIVE CARE**

A thesis submitted in fulfilment of the requirements for the award of the
degree

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by

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Student

0.2 Acknowledgments - *valuing the help*

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“the LORD is my strength”

Psalm 18:2

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0.6 Abstract - *glimpsing the whole*

The experience of pain is individual and subjective and only accessible to another by means of communication. Consequently assessing and managing the pain of a patient can be one of the most complex and elusive objectives of nursing practice. This is particularly the situation when critically ill patients are unresponsive as uncertainty impacts on the nursing aim of providing consistent, quality pain care. For me, as an intensive care nurse, uncertainty seemed out of place in the technological world of intricate measurement in the intensive care unit. The research work presented within this thesis focuses on making sense of and dealing with this disparity.

This study embraces both expressive and explanatory means of discovering and conveying knowledge. Nurses' propensity for storytelling inspired the development of an original, eclectic narrative method; drawing on, and extending the work of a wide range of philosophers and theorists such as: Labov and Waletzky, Gee, Agar & Hobbs, Richardson, Mishler, Johnson and Mandler, Reason & Hawkins, Ricoeur and Hegel. The research processes are comprehensively detailed in order to make apparent the realities of undertaking such work, and of accommodating the delays created by ongoing life challenges. In addition, the thesis is presented in a way that increases its accessibility to nurses working in practice, balanced with the need to work within established academic processes and structures.

While one still hopes for accurate measures of pain in unresponsive patients, the study identifies and discusses the few pain cues that nurses 'see', and the limited pain management options nurses 'do'. Furthermore, the space between 'seeing' and 'doing', where nurses 'think' and 'feel', was filled with rich complexity. Stories emerged of: learning about pain, nursing intuition and 'knowing the patient', decision making, advocacy for patients, collaboration with doctors, emotional responses of feeling stressed, frustrated, anguished and inadequate, the nursing mandates of providing comfort, care and justice, distancing from or connecting with patients.

The innovative narrative situatedness schema arising from this research offers a visual map of the interrelatedness of the study's dialectic concepts. The narrative ideas of constitute/constitutive are juxtaposed with expression/explanation. Additionally, the philosophical views on epistemology/ontology, synthesised to 'voice', are dovetailed with Robbins' pairs of human needs; certainty/uncertainty, significance/connection, and

growth/contribution. Such complexity is contained within storytelling. The study promotes a new valuing of an old skill in highlighting the role of storytelling to further nursing practice development. This revealing of the complexity of nursing provides a major step towards the ongoing enhancement of patient care.

0.7 My story in two voices - questioning my practice

Below is a verbatim transcription showing my voice as a clinician. I was sharing with another nurse in conversation about the event that launched the journey that culminated in this thesis.

Nerilee (Registered ICU nurse)

I guess my perspective was like... I'll tell you a story. When I first started there in the unit, 'cause I've only worked in our ICU and not other units, I looked after this man who was (this is one of the reasons why I've sort of gone in this direction and decided to do this research) this man, you know how we have guys from the park or from the street, who are derelict sort of people and they'd pulled the tube on him, and he didn't have a blood pressure, and I came on, and I was like, (I don't know how long I'd been there, a couple of months or something) and there was this morphine bolus written up for PRN and he'd been given it probably about two or three times in the last shift, and then when I was handed over, it had been given sort of four times in the last hour and handed over to me to give, you know, quite frequently cause he was supposed to die in the next however long, and he had a blood pressure zero and I thought, "Oh well, what am I supposed to do here, am I supposed to give a whole lot of morphine?", and he wasn't moving, you'd turn him over and he didn't.. nothing, just nothing. So I asked the person in charge and she said "I'll leave that up to you." (Laugh) It was like, "Oh, thanks a lot." and so I didn't, I don't know whether I gave it hourly or something and he went to the ward and he didn't die straight away. But then I did a pain subject in my conversion degree and that had nothing about these sort of patients, its all 'pain is what the patient says it is' type of thing, therefore the reverse is true, that comfort is what the patient says it is, and yeah what if they can't say so, then I decided to do this.

I must admit I have a real problem with that sort of thing as well, you know, the old, - It's okay for awake patients, like that definition I think, but you know 90% of our patients can't talk (laugh) or indicate or anything, so I thought I'd do, or I actually went through all the literature and there's hardly anything in the literature as well, so that's why I thought I'd research it, but I decided to talk to nurses, 'cause it's pretty hard to talk to the patients afterwards, or during or afterwards, and anyway what they can remember is not necessarily what happened.

(excerpt from interview 2: page 10, line 28 - page 11, line 33)

Below is a written piece showing my voice as an academic student. I was writing for my supervisors about the event that launched the journey that culminated in this thesis.

Nerilee (PhD candidate)

I was a novice to intensive care nursing and one evening shift I was assigned to a dying patient of low socio-economic status whose endotracheal tube had been removed earlier that day. He was unresponsive, breathing, with no measurable blood pressure. The medication chart contained a prescription for boluses of intravenous morphine to be given as necessary. I noted that during the previous shift morphine had been administered a few times but more frequently in the last hour and the nurse handing over to me suggested I give morphine frequently. I needed clarification on the indication for the frequency of giving morphine. I asked the nurse in charge of the shift who advised me to use my own discretion. I did not want to euthanase this man and yet I also did not want him to suffer. Having a firm belief in the autonomy of patients and the subjectivity of pain experience, I was uncomfortable with the lack of available assessment cues in unresponsive critically ill patients in intensive care, in either case, whether they were recovering or dying. During the nursing degree conversion course, I undertook a subject on pain, that addressed pain assessment and management in conscious patients, and subsequently a research subject in which I searched the current nursing literature for guidelines for pain assessment in comatose patients, but without success. I dismissed the idea of trying to gain an insight into patients' experiences of pain while unresponsive as I concluded that those able to convey their memories subsequent to being a patient in intensive care would be few and this information would exclude those unable to either convey or remember, for example, the neurologically impaired, those receiving an amnesic agent, and those who had died. I also believed that the experience of pain at the time was more important than the ability to remember. Therefore, I turned my attention to the nurses I worked with, to gain insights from them, to see how they undertook pain assessment when patients were not able to tell of their experience. I continue to wonder what that man felt during my shift as he lay dying, receiving a bolus of morphine each hour along with the other routine hourly nursing activities I performed for his comfort.

Chapter 1: Introduction

1.1 Thesis preview - *beginning the approach*

The significance of this study lies in an appreciation of and an investigation into the complexity of nursing, especially in uncertain contexts, with specific reference here to assessment of pain in unresponsive intensive care patients. The study uses an innovative dialectical approach that combines expression and explanation as a means of finding understanding in the complex situation of nursing unresponsive patients' pain in intensive care. When nurses, who want to be certain, understand the identifiable aspects of multifaceted imprecise situations, an informed and proactive approach, rather than spontaneously responding, would ensure more consistent and less haphazard care for those patients who were unfortunate enough to not be able to let us know what they were experiencing and would also allow nurses to feel more satisfied that quality care had been given. Through expression, nurses can give voice to their contextual understandings in ways that more accurately reflect the depth and breadth of nursing and in ways that can be more easily heard.

This thesis offers the significant contribution of appreciating how nurses work within uncertainty and complexity. In particular, in relation to understanding and accepting our ongoing uncertainty regarding unresponsive intensive care patients' pain experience despite our knowledge or skill level. In the end, I did not discover how to become confident through instruction, but rather found solace in knowing it is not easy for any of us, and yet, despite that communal experience of difficulty, I learnt that we can do our best.

The second important contribution emerging from this study is both a valuing of and an endorsement to use the nursing tradition of oral narrative expression in terms of telling what we do, 'our story', and the space we work within, 'their story', and thereby the movements that we can make both within ourselves and the workspace. I offer a conceptual dialectical narrative situatedness schema based on synthesising the concepts of explanation and expression; 'knowing' and 'being' into the concept of 'voicing'. One way forward spurred by this study may be a valuing of, and perhaps a formalising, of storytelling between nurses as a way of 'voicing' our practice experience and knowledge, supporting each other in situations of uncertainty and presenting a case for our assessment of pain in these patients to others within the multidisciplinary

team of intensive care. The narrative methods I employed are innovative in that I joined my colleagues in co-creating narratives that together formed a group collective story through layers of analysis of increasing depth. I offer the design of a structured practice development storytelling space for nurses based on the dialectical narrative situatedness schema.

The format of presentation of this thesis is intentionally unique in order to be true to the nature of expressive ways of sharing meaning. However, the real strength of the less formal presentation style is to enable accessibility to clinical nurses. I am a practitioner looking at practice wanting to return the wisdom gained back to practice. Especially in terms of the narrative methodology, through storytelling the thesis exposes otherwise hidden information for those of us who do not usually consume research in an easily readable way.

As was highlighted in the prelude of 'My story in two voices', in an effort to be 'heard' by members of both the academic and clinical worlds within which I live, the voice I write with reflects my synthesis of the dialectic of those two worlds. This study represents the location of synthesis between: academia and clinical, explanation and expression, constitutive and constitute, theory and practice, head and heart.

The activity of the thesis is presented as following the activity of nurses in their daily work in terms of 'seeing', 'thinking', 'feeling' and 'doing'. The culmination of these activities takes the form of 'voicing'. Nurses use visual cues and imagining to assess pain, cognitively interpret what they have observed, experience emotional responses to cognitive interpretation and take actions based on cues, interpretations and emotions. When my colleagues and I orally shared about these activities, the process began again with me as researcher gaining insights, adding more cognitive processing, expressing emotional responses and taking action through producing this work. My 'voicing' is contained in the words on the pages.

Comprehensive transparency of the research process of this study is readily available throughout these pages. In addition to offering detail of methods and analysis and the inclusion of examples in the appendices, I have also provided my reflective thoughts on each step taken. The trustworthiness of my research can be assessed by following the logic of decisions made and processes undertaken. Furthermore, the full disclosure of the development of the research process itself will benefit others undertaking research of a similarly complex nature.

The journey of this study was marked by a trail of major disruptions resulting in a lengthy candidature. Pertinent to this is the dating of the literature foundational to the study's formation. I have deliberately set out a comprehensive account of the work to show the reality and be true to the complexity of the undulating nature of undertaking an individual research project leading to a higher degree.

1.1.1 The research question

In the environment of adult intensive care, nurses manage pain and provide comfort for critically ill patients who are unresponsive [incapable of purposive actions]. Within this specific situation, I want to know the importance nurses place on the goal of a comfortable patient and what nurses 'see', 'think', 'feel', and 'do', and what else happens to help or hinder them in their management of pain and provision of comfort. I then want to present possible ways forward to a place where nurses might stand, intrapersonally, interpersonally, and contextually, in a climate that would be conducive for them to provide care that results in optimal comfort for these patients.

The next two sections set up the foundation of the study in terms of the interaction between my dilemma about pain, the ICU context, and my story as researcher.

1.2 Investigator background - *my story as researcher*

My history, assumptions and expectations impacted on this study. Researchers personalise a study and make it their own, regardless of the topic or methodology. Through motivation from the inner self, researchers glean from the literature, set up a study design, analyse, think and write. My study is no different. Because I was both a clinical nurse and a researcher, this study's form of narrative analysis as research process and the content of the substantive topic of pain resulted from facets of my inner self. This section will uncover features of the nursing situation surrounding me that particularly sparked my interest, as well as the ideas and beliefs held by me that gave shape to this study. In essence I will show the complex interplay of seemingly disparate tenets to which I held.

Not being an 'island' in terms of relationships and responsibilities meant that I brought to this study my 'related-self' as a woman, partner, mother, daughter, sister and friend; each with accompanying responsibilities. My 'work-self' as an ICU nurse limited the available time to do the research yet afforded me the opportunity to contribute my clinical insights to the study. Undertaking an individual research project leading to a

higher degree occupies a major portion of the researcher's available time as well as thought focus. Conversely, significant life events with competing responsibilities demand energy and resources. Over the time of this study there have been numerous major interruptions from losses and complications in other aspects of my life. My supervisors and the university have generously allowed me to focus my attention elsewhere during these breaks. Although this trail of disruptions resulted in a candidature that was lengthy and spasmodic in work, I have not succumbed to insanity or quit. Instead, only with strength and persistence, have I been able to pull together a comprehensive account of the work undertaken over more than 15 years. The work is set out to show the reality of the undulating nature of my research journey and for the work as a whole to be true to the complexity inherent in the process as well as the topic.

My intention in introducing myself as a nurse, student, researcher, and woman is to allow insights into what brought this study into being and what influenced the progress it took. The specific experience of being uncertain of pain care for a dying unresponsive patient presented in 'my story in two voices' triggered my search for certainty, yet the direction of the journey I undertook was dictated by what was within me at the time. In terms of my place as a nurse; I was a clinician, a bedside nurse, a nurse who got her hands dirty [and washed them]. I worked in an adult ICU in an urban teaching hospital, within an environment that had major impact on both patients in their illness and on nurses who worked there. My motivation for forging into this project was to become sure of my practice in making decisions regarding treatment options for pain in unresponsive patients. The state of 'being uncertain' was uncomfortable for me. Much of the physical nursing care in ICU was based on measurements. I found the discrepancy of being unable to assess pain via an objective measure yet being required to administer titrated doses of narcotic analgesia conflicting. For this part of my nursing practice my framework was empiricism, a philosophy that I will explain and contrast with dialectic philosophy as an alternative way of 'being' and 'knowing'. I assumed that it was possible to measure pain and not just guess its intensity.

1.2.1 About thinking that unconscious patients' pain might be knowable

Wanting answers to the dilemma of dealing with pain in unconscious patients gave impetus to my decision to undertake a pain management elective subject during my study for the Bachelor of Health Science - Nursing. I was disappointed, however, to find that the subject addressed pain only within patients that were awake and communicative. I wanted to know about sleeping and uncommunicative patients. I

wondered why unresponsive patients were not covered in the content of the pain management subject.

Content of the pain management subject was useful in that it increased my knowledge with respect to the physiology of pain and various pain management techniques. The most helpful part of this subject was the coverage of the methods of pain management which may be used as alternative or adjunctive to medication. Those that I considered included cutaneous stimulation and distraction, which could be used within the intensive care context but in my experience were not. I thought there could have been more consideration of non-analgesic comfort measures, especially in those patients whose analgesia doses were of necessity limited. I wondered why nurses in ICU focused mainly on pharmacology to the exclusion of other pain management options.

1.2.2 About only patients themselves knowing their own pain experience

Holding respect for the experience of others meant that I believed patients would know their pain experience better than I would. This respect for others' experiences resulted in my questioning the pain management practices where nurses assumed they knew better than patients what pain level was being experienced and when narcotics should be administered. It was during my general nursing training that I first observed a seeming discrepancy between the formal teaching of pain management and role modelling in the practice setting. In study block, the classroom view of the importance of pain being subjective was emphasised, whereas, when working with patients on the wards, it seemed nurses often managed pain according to an assessment of their own which sometimes was unaligned with what patients said. It may be that nurses act as if they 'know' in order to reduce the tension between potential horrendous pain that may be experienced by patients and what is within the scope of nursing practice to take measures to relieve such pain. Evidence of such was the giving analgesia by the clock and referring to patients who requested analgesia sooner than the four hour wait as 'wimps' or 'addicts'. Granted that there were pragmatic issues, such as the availability of personnel to obtain locked drugs, issues of prioritising, such as whether nurses thought to ask about pain to those quiet, stoic patients who would rather not cause a fuss, and issues regarding scope of practice, such as treatment options nurses might employ other than administering medication for pain.

In the literature section I will show the literature in which there are claims that nurses underestimated pain and that pain was frequently a persistent and significant memory of ICU patients when recovering. What I found alarming from my reading of the

literature was the discrepancy found between patients' and nurses' perceptions of what pain patients were experiencing. I became concerned that there were few cues on which nurses could base judgement of pain when patients were not able to move or indicate with purpose. As a result, I imagined nurses could easily overlook pain to some extent. In addition, I also knew that there were categories of patients who would be unable to report their memory of ICU, for example, those patients who underwent pharmacological amnesia, who were neurologically impaired, or who had died. I was concerned that nurses would need to know what unresponsive patients were experiencing during the time that they were in pain particularly when patients were unable to report their memory of their ICU experience after discharge.

My concern for unresponsive patients increased by noticing a relationship between the changing of nurses each shift and the variability of doses of narcotic analgesia given. Some nurses seemed afraid of giving too much analgesia and commented on the possibility of addiction while other nurses seemed to be liberal. I wondered how patients could receive a consistent level of comfort when the frequency of analgesia doses or the rate of analgesia infusions was disparate. Even more concerning was the situation where patients' analgesia administration was suspended or ceased by doctors during circumstances of weaning from mechanical ventilation, neurological assessment and organ failure. I noted the frustration of nurses who believed patients were in pain but were not able to administer what they thought was the necessary level of analgesic relief. At work I was faced with new nursing staff members asking direction questions, "How do I...?", and doctors prescribing pain management in ways that were at times inconsistent or which I believed left some patients in pain for the sake of recovery. I wondered what this was like for my nursing colleagues.

1.2.3 About complexity of competing priorities

I worked in a place where the priority was to keep patients alive who were near to death and so it was often the case that treating pain was not the top priority. In fact nurses even had to intentionally inflict pain when assessing neurological function or inadvertently and unintentionally caused pain whilst doing other procedures to patients. Seemingly, nurses coped with believing pain was experienced by patients to some undefined acceptable level while working hard to keep these patients alive, but when the crisis was over nurses also wanted patients' pain under control. There were also times when the decision was made to allow patients to die and then, when staying alive was no longer an issue, seemingly neither was the amount or frequency of analgesia.

Noticing these attitudes in my workplace made me wonder how nurses managed the balance of comfort and cure.

I searched the pain literature, specifically that of nursing assessment of pain. I was looking for pain assessment in the intensive care context or at least assessment of pain in patients unable to describe their pain, however, there was little research that investigated what it was like for nurses to care for the comfort of unresponsive patients and make decisions regarding their pain management. This lack of material led me to be interested in researching the area.

I began this study uncertain of my own decision making about treating pain when I couldn't measure it. I assumed that a way of measuring or at least being certain was located within other nurses or the published literature. I found through my reading that pain assessment was in fact a problem area in nursing. I was concerned for unresponsive patients as a result of noticing variability of pain management in my workplace, and so I wondered how to access nurses' wisdom but also how to obtain the whole picture of what was going on.

The selective approach of other studies on assessment of pain often provided scenarios or vignettes on which nurses were to base their responses. I felt that those studies were incomplete or inadequate in that they did not allow a look at all the factors that would have some bearing on what would influence my assessment of pain. I wanted this study to cover the whole picture. Initially my research goal was to document the clinical decision making process of nurses in ICU in order to learn how these nurses made decisions about assessment and treatment of pain in unresponsive patients. I could then evaluate whether this decision making process was teachable, so that expert nurses would teach novices how they made decisions about pain. I thought I would then have provided nursing with the information for which I had been searching in vain. However, my reading of the literature, together with my experience working as an ICU nurse made me acutely aware of the complexity of the situation that I wanted to investigate.

From my general hospital training through the intensive care certificate and into the conversion degree, I found that high ideals are taught formally to nurses, whereas in the reality of practice those ideals are difficult to attain. Being an idealist meant that the discrepancy between ideals and practice set up a tension within me. There seemed to be two options in resolving this tension. Firstly, I could lower the ideal to which I had

hoped to attain, however I found this unsatisfying. Secondly, I could endeavour to improve practice, which is the option that motivated this study.

1.2.4 About valuing nursing and external confidence

I brought to this study a high regard for the worth of nursing. I had a firm belief in the holistic nature of nursing practice, knowing the intent of nurses to care for the whole person of each patient. As such I valued nursing and what nurses offered to each patient's overall health care. I placed the significance of nursing work in the holistic outlook, the caring focus, the length and continuity of time spent with patients and that nurses see patients in changing circumstances. I knew that nurses were the eyes, the watchers, the mediators, the first line of alert. I thought nurses held a 'body of knowledge' within their profession. When I observed other nurses make decisions about pain in unresponsive patients with such seeming confidence I wanted to tap into their knowledge.

After failing to find pain assessment criteria for unresponsive patients in the literature, my assumption was that other nurses may have more knowledge. In fact, I wanted to know the practice thinking of other nurses who were apparently confident as they went about assessing pain in these patients. Underlying all of this within me was a firm belief in the value of nursing. Nurses' work is vital to patient outcomes. Holding the value of nursing meant that I would not defer to the patient assessment of other health carers but believed that nurses were in the best position to detect cues to indicate the possible pain experience.

It was my firm belief in the significance of nurses' work and the valuable position they are in to make a positive impact on patient outcomes that gave strength to my desire to be able to make a difference, although at the beginning of this study I found asserting myself challenging. This mix of traits brings a quiet determination that can be stressed or discouraged but finds ways to hang on and to move forward. Respecting others' thinking as well as the curiosity factor has led me to want to know others' points of view and thus in this study valuing my colleagues input. However, this also applies to patients where I would always respect their version of their experience. Probably the frustration engendered by low assertiveness would contribute towards the direction of some of the content of this study regarding nurses not being heard by doctors. I may be representative of a section or historical time of nursing being depicted as subservient, nevertheless, I present this side of me up front as an awareness of my influence in terms of shaping the study. However, my belief in the significance of

nursing meant that I solely looked from the nursing point of view and did not extend my area of research to include others in the multidisciplinary team nor the patients.

1.2.5 About sensitivity and seniority

I was an empathetic type of nurse who tended to easily see suffering and maybe was more prone to the stress of identifying myself with patients. The nursing manager had consistently put work allocation practices in place to avoid nurses becoming damaged through close and prolonged interactions with the same patient. In addition to the belief that pain is a subjective experience and patients know best what they live through, I wanted patients' current experience to be what nurses took notice of rather than what patients might have remembered or what nurses assumed about patients. I believed that there were patients who experienced pain but did not remember. Some patients could not convey their memory because they may have been given amnesic agents, suffered neurological impairment or death. My concern was that the pain experienced at the time would have impacted regardless of the memory of it. I was concerned that nurses empathising with the possibility of patients' experiencing pain might hold some element of harm for nurses [and **nurses'** memories cannot be erased with amnesic agents!]

The beginning event of 'my story in two voices', happened very early in my time in ICU. Being new to ICU, even though I had experienced a variety of nursing settings over a few years, meant that I was still feeling out the way nursing was conducted in such an acute context. When I was unsure of what to do, I hoped to learn by watching and asking advice from other nurses. However, learning from role models was fraught with difficulty because practice varied and the nurses that I approached were unable to explain the rationale for their practice when they also were uncertain. Observers are not privy to what the sufferer is feeling and so nurses must act on their own judgement of patients' pain. I thought that finding out how ICU nurses judge pain when patients' words are unavailable would help formulate a guideline for nurses to follow.

By the time I actually spoke with my colleagues at the formal information collecting stage of this study, I was not only seen as a senior nurse in the hierarchy, but also known for studying pain as a topic of interest and perceived by others as knowledgeable in the area. I believed that this perspective had the potential to interfere with ease of nurses offering their information to me. Therefore, I supposed that I had to counteract nurses seeing me as a pain expert by making clear my intention to find new

information through talking to them about a specific area of pain management where little seemed to be known.

Events that had nothing to do with this study impacted on it anyway. Throughout the study my personal life continued but having a thesis always in the background of my mind magnified any other life event to become almost overwhelming. The years have matured me somewhat, both in terms of personal confidence and perspective as an ICU nurse and in the way I have continued to carry the question of my thesis. I hope this depth of perspective is discernible in this thesis.

1.2.6 Summary

Assuming the experience of pain was detrimental to patients meant that, as an intensive care nurse, I prioritised efforts to minimise the inflicting of pain, reduce the experience of pain and provide comfort to patients in my care. However, believing that the basis of decision making in my job was logical, rational, and based on evidence meant that when faced with making decisions about pain I felt that I needed the information that unresponsive patients were unable to give. Other information available that I could use in my decision making process was ambiguous and removed from this immediacy. With the belief that nursing is crucial to patient care in terms of noticing and voicing, I valued my role in assessing pain and felt responsible to obtain the best care for patients through liaising with other health professionals, however, I also knew the frustration of being prevented from functioning within my beliefs and values when my nursing care was determined by powerful others. A belief that other ICU nurses had more knowledge because they showed apparent confidence in providing pain care led to a curiosity to find the basis of such security.

When confronted with the seemingly unknowable in terms of unresponsive patients' perception of their pain experience, I sought find a way of knowing so that I could be sure patients' pain would be managed well. Persisting with a study of this depth and duration reflects the strength of my motivation. For me the motivation was to overcome the inexactness of pain assessment in ICU so that nurses might be sure and patients might be well managed. There is something about the certainty of ICU where nurses are able to objectively measure and know in detail so much physical information about patients so as to forestall the unexpected, to be a step ahead of demise, to ensure recovery from a physical crisis that makes for a controlled space. There is something about me that suits this preciseness. I was led to this study through questioning the appropriateness of guessing in a context of such accurate measurement and assuming

that patients experienced more than nurses knew about. I am uncomfortable with uncertainty. I like to know what is happening inside patients, thinking that the more I know the better I am able to care for them. The push from within me was to find a way to be more sure of my practice so that patients would receive better care.

My beliefs about people, nursing and myself were integral in shaping this study yet, because the specific situation I encountered that prompted this study occurred in the ICU setting where I worked, that setting also made its impact on the shape of this study. The next section deals more closely with the foundations of exactly what problem exists with pain assessment in ICU and why it is a problem worthy of investigation in this study.

1.3 Context of topic - *locating the problem*

In the previous section I showed that my place in this research included my personal experience of pain assessment as I practised nursing and my exposure to patients' memories of pain. Experiences I encountered whilst nursing gave impetus to my questions about pain and the beliefs and values I held gave shape to this project. I now turn to the problem area this research addresses regarding the difficulty in assessing and managing pain in unresponsive critically ill adults within the ordered chaos of the intensive care environment. I present information in this section from my perspective rather than that of the literature.

Firstly, I will show through the context of the physical world of crisis and the urgency surrounding critically ill patients in ICU why it is that technology can claim the limelight and that the contact between technology and patients can cause pain. Secondly, I will explain why some patients are unable to intentionally communicate their experience and although there are some who remember pain from this state, these patients' pain cannot be objectively measured and therefore nurses have to guess its intensity. Thirdly, I will reveal how the priority of saving lives impacts on promoting comfort especially through the interplay between members of the multi-disciplinary team, particularly the nurses' relationship to doctors. Finally, I will clarify why I wanted to relieve the negative consequences of uncertainty on both patients and nurses in terms of possible inadequate pain care and coping with working 'in the dark'.

1.3.1 About patients, ICU, technology and pain

To the uninitiated, ICU is an alien environment. If you have not seen inside an ICU then I want to make it easy for you to feel what it is like there so that you know some of what it is like for nurses to work in such a place. Equipment, light and noise dominate the scene. Each bed area is cluttered with equipment for monitoring and assisting body functions, administering intravenous infusions, draining body fluids and copious forms and charts on which to document happenings. Some of these patient areas are isolated, where patients harbouring infectious micro-organisms or those with poor immunity are located. There is a central area where phones need answering, x-rays can be viewed, patient charts reviewed, and computers used to enter data, to store and retrieve information. Side rooms contain places for the disposal of waste, storage of supplies and extra equipment. In another part there is space for visitors to wait, a place to make coffee, toilets, a room for staff to go for their breaks and various offices and education rooms.

Because the physical environment of ICU is a bright, noisy, cold place, with an atmosphere of crisis, where there are displays of measured objective data, and alarms are heard alerting staff to the prioritised actions directed at sustaining life, consideration of pain requires thoughtfulness, effort, and a look that is wider than the urgent. The physical surroundings of ICU exist to be ergonomically useful. This is to enable the interface between staff, the space, furniture and technology to enhance smooth work practices in order to ensure efficiency in efforts directed towards saving the lives of critically ill patients. Yet a paradox exists because the complexity of the physical scene can be overwhelming and the patients, for whom the scene is set, may fade into the background.

After having sustained injuries or undergone operations that have broken tissue integrity, patients then endure ICU monitoring and treatments that are often invasive. The interface between patients and technology affords its own disruption to normality through the attachment of patients to machines and the associated varying levels of discomfort. Firstly, attachments at skin level, such as: adhesive ECG dots and clip-on oximeter probes, can cause pressure, allergic reactions or simply annoy. Secondly, atraumatic attachments via orifices, such as: nasogastric tubes for feeding and rectal probes for recording core body temperature, invade body spaces and irritate sensitive internal tissues. Thirdly, traumatic attachments invade the body through the skin, such as: catheters inserted into arteries that are continually measuring blood pressure and

lines inserted into central veins that are recording fluid volume and are used for administering fluids and drugs. Traumatic attachments of technology to patients disrupt skin integrity causing pain and open patients to the risk of infection that could ultimately lead to more discomfort. Sicker patients carry more attachments and endure more invasions.

Insight into unresponsive patients' possible experiences was made available to me when one patient spoke of her experience as an unconscious patient in ICU. This woman came back to the unit after she had recovered from a motor vehicle accident. She talked to the nurses during an afternoon tutorial and told what she could remember of her stay in the unit - not much except being turned - it was so painful that she felt she was falling down a bottomless pit. So I became more aware or observed the patient's reactions more when they were physically moved in bed. Another patient spoke at an ICU conference I attended. When he was asked about memories of his ICU experience, he said that suctioning was the worst experience and that physiotherapists were more gentle than nurses. He also hated it when the person suctioning said "Just one more time". Subsequently, I tried to be more gentle when I was pushing the suction catheter down the endotracheal tube and was more aware to not say, "one more time." Being exposed to these patients' memories of their ICU experience influenced my practice. I wondered how previous patients impacted on nurses' practice.

1.3.2 About patients' inability to communicate

Knowing about the experience of being critically ill usually becomes available to nurses after patients have recovered or at least when they can speak, but there are patients who either do not recover or live with limited ability to communicate and for nurses their experience of ICU remains a mystery. Occasionally critically ill patients can intentionally indicate their experience. Other unresponsive patients have experiences that are extremely difficult to discern due to the nature of their illness or the drugs with which they were sedated or paralysed. These patients often appear asleep if left undisturbed and, if able to move at all, are capable only of reflex type actions, for example, coughing in response to suction or showing body tension, erratic movements and facial grimacing in response to change of position or procedures such as insertion of lines or dressings. They cannot talk, write, point, nod or pull faces. Their communication is severely restricted.

Therefore pain assessment in ICU is fraught with difficulty because it is often not possible to obtain a critically ill patient's account of their pain. Reflex responses, autonomic nervous system changes and observable behaviours are remaining indicators when verbal communication is impossible. Reflex reaction to pain, such as flexion or extension, forms part of assessment for neurological deficits within the Glasgow Coma Scale, however, the response elicited may not indicate the degree of pain experienced.

1.3.3 About nurses working within team priorities

Because of so much contact time with patients, nurses are in a good position to manage comfort and pain. Impacting on nursing actions is the involvement of other multi-disciplinary team members working closely together within the ICU setting. Doctors have the most influence on pain management as they control the prescription of narcotics and nurses contend with the residue of the longstanding fraught power relationship between doctors and nurses.

Just as the physical setting of ICU results from surrounding patients with technology, the social setting is created by surrounding patients with a multi-disciplinary team of health professionals and ancillary staff who all contribute in some way to care of patients. This care can be highly structured or very changeable depending on the seriousness of the condition of the patient. Constituting a large number of the team are bedside clinical nurses who may be routinely recording observations, suctioning, turning, attending to hygiene needs, giving medication, infusing fluids, answering typical questions from concerned family members; or minute-by-minute the changing needs of the patient may require instant responses from taking extra physiological measurements, to giving additional drugs, to resuscitation measures and family crisis management. While concurrently monitoring the progress of patients, giving patient care and being led and guided by other nurses involved in management and education, nurses are liaising with doctors and others on the team for their distinct expertise. Physiotherapists, occupational therapists, speech therapists, pharmacists, social workers, ministers and pastoral care people doing routine rounds during daytime hours or being called when needed, are not continually represented within the team. Through organising information, clerks assist with efficiency within the team as do cleaners, by preparing clean bed areas to prevent delay of patient transfers. The contact timing of diagnostic technicians and wardspeople impacts on the team by either assisting or interrupting bedside care. Responding to the changing needs of ICU patients can also throw doctors' routines into chaos. Although being in an intrinsic hierarchy of

consultant, registrar and resident, any doctor within the team is at various times responsible for examining patients, deciding on the medical course of action, ordering treatments and has the privilege of holding the most authority when speaking with relatives of patients.

Spending time in intimate contact with patients allows team members the opportunity to assess patients' needs. The intensive care unit where I work usually has a ratio of one nurse to each patient, although at times one nurse may be required to care for two patients. During this study, the length of contact time for nurses at the patient bedside was six or eight hours during the day and ten hours at night. Each new shift brought contact with a different patient. Intensive care doctors (consultant, registrar and resident) would do rounds of the patients twice a day, thoroughly in the morning at about 1000 hours and as a check in the evening at about 1700 hours. A resident ICU doctor was present in the unit and could be approached to look at patients at any time. The registrar and consultant were sometimes present at times other than rounds but more often were available to be contacted by phone. Other specialist teams of doctors arrived at any time of the day to check on their patients. Nursing allocation and other unit routines allow nurses as a group the most contact with patients over a shift, however, changing nurse/patient dyads each shift does not necessarily allow one nurse to know one patient well over their stay in ICU. Doctors have the benefit of observing all patients on a daily basis but compared to nurses' contact over a full shift, doctors' contact time with patients is less extensive and intimate. Indeed, over a patients' length of stay doctors may have a better global view while individual nurses may more intimately know specific patients.

Doctors have a major impact on nurses in ICU because members from both professions work together more intensely and in closer proximity than in other health settings. From the cross-section of staff that form the multi-disciplinary team in ICU, nurses work more closely together with doctors. Through existing norms of social status and power together with personalities found within the team, patterns of functioning together and relating to each other are such that doctors hold the power in the decision making of the team. This power, especially evident in doctors controlling the most powerful pain and comfort treatment options, narcotics and sedation, and making decisions about ending treatment, impacts on nurses' ability to cope with their own work. The personal confidence of individual nurses affects their efficacy and how frustrated they may feel.

As 'my story in two voices' shows at the beginning of this thesis, as a new RN in ICU, the complexity of the situation came to the fore when I had to decide how often to give PRN [from the Latin 'pro re nata', for an occasion that has arisen, as circumstances require, as needed] boluses of intravenous narcotic analgesia to unresponsive patients. The doctors prescribed the amount and the nurses determined the frequency. During my time practising as a nurse in ICU, there has been a shift from administering boluses to infusing narcotic analgesia. The dilemma for nurses in administering narcotic analgesia remains as doctors order the concentration of drug for the infusion and the nurses may change the rate of infusion until the patient is at 'level 2' of pain on the Pain and Sedation Chart [Appendix O]. The pain and sedation chart defines 'level 2' of pain to be 'mild pain' on coughing, physiotherapy, dressings, turning or similar procedures. Although infusing solves the problem of frequency of analgesia administration, uncertainty continues when deciding the rate of the infusion. Reasons for infusion rate changes or boluses are to be documented on the pain and sedation chart each hour, however, there is no definition of 'mild pain' other than its comparison to the remaining categories of pain; 'none', 'moderate' and 'severe'.

Because there is a degree of flexibility inherent in the doctors order of narcotic analgesia, nurses have some autonomy in treating pain during the normal course of events. Flexible orders which allow for PRN administration of analgesia, based on my experience as an intensive care nurse, result in variation in the amount and timing of analgesia given to patients. For example, during one shift, an unconscious patient may receive hourly intravenous morphine boluses while during the previous shift only two doses may have been given.

However, in some situations, nurses' autonomy is removed by the doctors. For example, when the patient is to be 'woken up' for neurological assessment or to wean ventilation, or if the patient has some sort of contraindicating condition which prevents them receiving normal amounts of analgesia, they may receive none at all. It was perplexing to me when doctors ordered no analgesia to be given to patients in acute renal failure, as the metabolites unable to be excreted would remain within the body for a long time and the doctors claimed that these patients were not experiencing pain; the facial grimacing and tense body posture were a result of uraemia. One patient who had a huge cavity in the back of his neck resulting from debridement of a necrotising lesion had an order not to give narcotics because the patient had diabetic ketoacidosis, was in acute renal failure. Did he experience pain at any time but especially during his dressings? During these situations, nurses are faced with a full 8 hours of managing a

patient who would likely be in pain, whereas the doctors, who have left such instructions, may appear at the bedside once or not at all during that shift. Each shift nurses deal with invasive monitoring and procedures that are employed to keep critically ill patients alive, also painful stimuli assessment for neurological function, besides the routine maintenance cares of changing position and removing tracheal secretions causing coughing, that we assume would hurt.

When I realised that, in some circumstances, nurses' treatment of pain in patients was constrained by doctors' orders, I extended my area of interest to include a look at elements external to the nurse/patient dyad which impinge on nursing of these patients. What do nurses do when their pain management options are limited? How do nurses cope with not being able to relieve pain?

1.3.4 About the negative consequences of uncertainty

Not knowing for sure the pain experience of patients who are unable to tell, nor the outcome of nursing actions in promoting comfort for them, can have detrimental consequences for both patients and nurses, It is these unfavourable consequences that I would like to alleviate by undertaking this study. Variability in assessment and management of pain resulting from the unavailability of objectivity cannot be good for patients. Nurses use subjectivity as a resource which leads to guesses that are multiplied by the number of individual nurses. Complicating the picture and adding to the variability are nursing responses to the ever changing, complex environment of ICU. Providing inconsistent pain management, especially under-treating pain in critically ill patients, is likely to inhibit their healing or add complications. This can cause disruption to the expected recovery trajectory possibly leading to an increased length-of-stay in hospital. For nurses, the degree of complexity and difficulty in assessing pain and providing consistent and evidence-based pain management to patients, for whom there is no objective measure to assess their discomfort, is extremely challenging. Thinking of the possibilities for these patients leads nurses to consider that they may be in extreme suffering. What priorities would these patients want nurses to work on? How do nurses cope knowing neither patients' wishes nor what they are feeling? Being uncertain of the outcome of care may cause nurses stress leading to a variety of coping measures which in and of themselves may impact on the care given.

Patients are in ICU because they are close to death, with the unresponsive patients that I am focussing on probably being the closest to death, yet nurses intend for them to live. Nurses work within a tension that exists between how much pain patients may

be required to bear whilst hanging on to life whereas dying patients are expected to be managed so that they are pain free. Nevertheless, patients come to ICU as a life-saving measure and undergo invasive and painful procedures to avoid death. Comfort is not always the highest priority, however, I believed that consideration of comfort was important in the management of these patients because of the detrimental effects of pain; stress response and the resulting deterioration in condition. I was disturbed to observe painful stimuli used as a short term measure to maintain blood pressure in hypotensive patients. This showed the predicament of nurses needing to balance between comfort and life-saving mandates yet fulfilling both to the ideal was sometimes impossible. During this time, I became more aware of the interrelatedness of pain and comfort. I tried conceptually placing them on the two extremes of a continuum. I thought that the promotion of comfort would contribute to pain relief and that treating pain would help patients to be more comfortable. My area of research interest included a consideration of the priority nurses gave to comfort in their management of these patients and the balance of comfort and cure.

The gaining of additional knowledge on a subject is one way of overcoming uncertainty. Because I had learned by observing how my colleagues nursed unresponsive patients and listening to the stories of what it was like to be such a patient from those who had recovered and could remember, I became interested in how this process of gaining knowledge had happened for other nurses. My research question grew to include a look at how nurses learnt. What had influenced nurses to have the viewpoints they held about comfort and pain in these patients? How did nurses learn what to look out for as cues of comfort or pain? What was their journey?

1.3.5 Summary

Within ICU clinical practice, I noted an effort to adhere to the idea that pain is a subjective experience only known to the person suffering, with the unfortunate possibility of ignoring those patients who could not express themselves. Possibly, ICU nurses slip into the thinking that they know best for patients when they cannot ascertain patients' wishes. Within the ICU where I worked, the unstated assumption seemed to be that if the unresponsive patient is on a morphine infusion their pain has been taken care of and they are comfortable.

1.4 Thesis overview – *providing the map*

I will give a foretaste on what is in each of the eight major chapters of the thesis.

Chapter 1: Introduction

In section 1.1 Thesis preview - *beginning the approach*, my search for certainty about pain led me to complexity in nursing. The thesis brings the contributions of storying complexity, in terms of topic of pain and in terms of the process of the thesis, in a clinically accessible way as well as a schema for nurses to use to organise formal storying.

Section 1.2 Investigator background - *my story as researcher* is about being a clinician practising within a clinical dilemma that caused me internal turmoil because I was expecting quantifiable therapies to be based on objective measurable assessment. Turning to formal learning and the literature did not resolve my dilemma. Valuing nursing practice, because we know more than we say, I set out to find the collective wisdom of my colleagues, even though they thought I was the 'pain expert'.

Section 1.3 Context of topic - *locating the problem* reveals the milieu of crisis and reliance on technology in intensive care that can distract nursing focus away from pain assessment, yet that same milieu can cause patients pain. Pain is a subjective individual experience that can only be understood by another person through expression. When patients cannot intentionally express their pain, nurses continue to assess pain and adjust narcotic analgesic delivery accordingly. I wanted to know how it was more than pure guesswork.

Section 1.4 Thesis overview – *providing the map* [you are here!].

Chapter 2: Literature

Section 2.1 Literature review - *seeking the known* presents previously published research to lay a foundation for the study. We know that pain is detrimental to health, the severity of pain experience is linked to the meaning placed on the pain, yet pain can be a significant memory of patients who were unconscious at the time. Pain generally tends to be underestimated and under-treated by health care professionals so where does that leave the vulnerable group of unresponsive patients who cannot express their pain? There was information on pain theories and methods of

assessment but a dearth of information on unresponsive patients' pain provided a space for my research to show real complexities.

Chapter 3: Methodology

Section 3.1 Journey to methodology – *broadening the exploration* outlines my movement from seeking a straightforward, easy to follow clinical decision making guidelines as a solution for my pain assessment dilemma to appreciating narrative as a methodology that catered for complexity. As a clinician I knew that what happened in practice was more multifaceted than could be addressed using clinical decision making and seemed broader and more complex than the core concepts of grounded theory or the individual experience of phenomenology. Stories captured my attention and spoke to me at a deeper level about what was happening for nurses in terms of the passing of and placement within time, the surrounding context, our own identity and our way of relating to others.

In section 3.2 Refinement of methodology - *following the narrative*, I traversed the vast variety in the ways other researchers have worked with narrative structures to gain insights and produce new knowledge and then chose my own ways through this maze based on what worked. I moved from looking at structural and linguistic forms of meaning to the idea of shared 'voice' in a collective story and then onto expressive responding as co-operative inquiry.

In section 3.3 Positioning of methodology - *finding the story*, I showed how narrative expression covers such a broad scope in terms of finding what the happenings mean to the teller, what they think of themselves and their relationship to people in their story and their audience, whether they are proactive in story creation or merely acting in another's story. These insights can be seen at various levels of relating to the story from structural analysis and linguistics to listeners' responses. The dialectical stance of considering opposites to find a synthesis helped me deal with the ever increasing dichotomies appearing within the concepts of the thesis.

Chapter 4: Method

In section 4.1 Data collection - *welcoming the stories*, I intended to draw as close as possible to the story of actual nursing practice whilst still conducting a research project. I chose to audio record one shared conversation with each of ten of my clinical nurse workmates in intensive care, as we shared the dilemma. I deliberately put in place ways to keep our relationship as colleagues, rather than the inequality of researcher

and participant. I chose not to overtly seek anecdotes but let them arise naturally in the conversations, as they would then be relevant to the point being made, and in the same manner I shared my anecdotes with them. Through each conversation we co-created our practice story.

Section 4.2 Analysis - *working the stories* describes how: tapes were transcribed, texts were analysed using narrative techniques, I moulded a collective story from our stories, I created a metaphor, and I expressed some of the participants' striking metaphorical words in a collage poem. Recording a comprehensive audit trail and providing examples for viewing in appendices allows others to confirm appropriateness of choices made and processes completed. I exhibited congruence throughout the stages of looking for an answer then finding complexity by allowing stories to attend to that complexity and provide depth through the presence of both explanation and expression. In the end the readers' responses will be significant in this process.

Chapter 5: Findings

In section 5.1 Metaphor – *exposing the dark*, I responded with expression as an avenue of knowledge building that embraced the purely self emergent metaphor, of us nurses working within a dark room, which I wrote while analysing the transcripts. Depicting knowledge as light and lack thereof as darkness allowed me to conceptualise the working out of our practice within uncertainty.

Section 5.2 Collective story - *creating the blend* puts together the co-created practice stories into one collective group story using narrative structural concepts to guide its form in an effort towards readability and retention. The formation of a collective story also has empowerment value for the group in terms of individual members being similarly situated and the combined voice being more often heard.

Section 5.3 Poem - *expressing the pain* values the strength of metaphorical expression in poetic form. I searched for metaphors from my colleagues scattered throughout their transcribed words and after placing them in similar idea groups, arranged the whole as a powerfully emotive poem on being a nurse within the uncertainty of their pain experience and yet knowing the critical nature of their physical condition.

Section 5.4 Focus - *presenting the issues* shows my formational thinking in the journey of analysis and the progression of concepts and visualisations that led me to a clearer understanding of the emphasis of this thesis. Pictures and colours seemed to be

predominant in my thinking leading to a display of diagram and sections based on the 'darkness' metaphor.

Chapter 6: Interlude

Section 6.1 Pausing – *linking the concepts* provides an opportunity to gather together the ideas previously presented and to facilitate a readiness to receive the new knowledge emerging from the synthesis of these ideas. I created a new visual schema to enhance understanding of how the dialectic concepts are situated in relation to each other.

Chapter 7: Synthesis

Through section 7.1 Pain care - *seeking certainty in 'seeing' and 'doing'* I showed that because we cannot definitively measure, we put together a multifaceted picture according to what we can glean and depending on how motivated we are to look. We may look for physical signs of pain but these can be confused with their critical illness. We may refer to our understanding of the pathophysiological processes of their illness or injury or the invasive procedures we have applied, and then consider the subsequent tissue damage. We may remember patients that were conscious with similar problems and juxtapose their pain experience onto this unconscious patient. We may imagine ourselves as them and treat them as we would like to be treated. We may only be prompted to think of pain in the presence of the patients' families. Thinking they are the most effective, we most often use intravenous narcotic infusions for pain, however, we also use provision of comfort measures in hygiene and positioning to minimise unnecessary pain. We used talk to prepare for intentional pain and to reassure. We mentioned possible other alternative measures that may sometimes be considered like aromatherapy and massage.

In section 7.2 Epistemology - *thinking through uncertainty*, by looking at nurses 'thinking', we can understand that even though the nature of critical illness is such that unpredictability is certain, constant sources of measurement surrounding patients ensures that at any one moment we are certain of which direction the patient is heading. Suggestions were made for inventions for measuring pain in the future. For some nurses, the tension between wanting certainty and nursing within uncertainty was resolved by gaining more knowledge or assuming certainty on an intuitive or gut basis. Other nurses seemed to be able to live with the uncertainty, valuing their care, advocating for patients, contributing their nursing input with the multidisciplinary team and aiming to be doing their best.

In section 7.3 Ontology – *'feeling' within uncertainty*, I found my colleagues wanted certainty and described as difficult the uncertainty that they worked within. Nurses chose to cope by attaining significance through fulfilling roles mandated by doctors or the profession or achieving connection with patients. Nurses focussed on tasks and prioritised recovery to maintain enough distance to keep ourselves safe.

Section 7.4 Storying – *'telling' of practice* is about practising nursing 'voicing'; that is a conceptual space between explanation and expression that represents wholeness, breadth and depth. It makes sense to draw closer to the path of explanation for more quantifiable aspects of nursing and more towards the path of expression for the messy murkiness of human relationships. However, keeping our practice in touch with both options allows for flow and movement and reflective appropriateness in our choice of response to each nursing challenge we face. Nurses naturally tell stories to each other. However, I aim to enhance the importance of this informal exchange in terms of knowledge formation, encouraging more to take place and the environment between nurses to be supportive to facilitate such sharing. Additionally, valuing storytelling in more formal settings and in terms of making a case to other health professionals would enhance the worth of what nurses see and do.

Chapter 8: Conclusion

Section 8.1 Ending – *'knowing' the practice* shows how this thesis contributes to the nursing dialogue on pain, specifically those patients unable to tell us of their experience, on research methodology that can handle complexity, on the realities of the interaction between research and life and on the conceptualising of how dialectic narrative tensions can be 'voiced'.

Appendices

The appendices are numerous and voluminous because I intend to show a clear audit trail of my thinking and the processes undertaken in this research. There is cross referencing to relevant appendices in the body of the text.

The literature that I accessed in the pursuit of knowledge about the pain experience of unresponsive patients is next in chapter 2. Even though I did not find definitive instructions for accurate assessment of critically ill patients' pain, other pain information from the literature filled in the gaps in my knowledge and provided an informed basis for undertaking this research.

Chapter 2: Literature

2.1 Literature review - *seeking the known*

As was detailed in the previous section, especially in the intensive care setting, the phenomenon of pain presents a special set of problems. The nature of critical illness or injury ensures pain as a likely experience and the environment of ICU as well as monitoring and treatment may in fact inflict pain. In addition, technical apparatus and altered conscious levels impede such patients in conveying pain messages to nurses. In this section, the concepts that apply to my aim to better assess pain will be presented from the literature that was current at the commencement of this project and integral in the formation of my research query.

Even before embarking on this study, I searched the pain literature with the express aim of finding instructions on how to best assess and manage pain in unresponsive ICU patients. My journey through the pain literature did not reveal the answer I sought but did provide me with other pain related information that was foundational to the understandings that I brought to this study as researcher and therefore the setting up of method and questions. Literature reviews may be arranged in several ways and I considered organising the pain information gained according to chronology, works produced locally, nationally or internationally, or works involving general nursing or specialised ICU nursing. However, I have settled here on my original approach of a logical development of ideas about pain, built one upon another, much the same way as the literature unfolded. I have chosen to exclude the more current literature on the ideas about pain presented here in order to remain true to the information on which I built the study. Information procured during my undergraduate studies in addition to CINAHL and Medline searches of the literature to the early 90's is covered here. The synthesis section contains information from more current works from the literature in relation to these beginning ideas about pain as well as other thoughts on pain developed through my research.

Within this section, the literature reveals how pain theories have evolved over time, from simple cause and effect to complex involvement of varying nerve types, spinal cord sites, brain centres and transmitter substances. Even though there is a need for pain to be understood by nurses, because patients in pain are frequently encountered during the practice of nursing, conceptual models in the nursing literature typically omit

pain. However, a helpful way of conceiving pain experience is the cumulative addition of nociception, pain, suffering and pain behaviours. Although pain is defined as whatever the person experiencing it describes it to be, the literature shows that health workers prefer objective measurements on which to base pain assessment. Especially in the intensive care setting, the phenomenon of pain renders a special set of problems as technical apparatus and altered conscious levels impede the patient in conveying pain messages to the nurse. The literature shows that ICU patients' communication difficulties hamper pain assessment leaving nurses to gather only observable data. Physiological signs of sympathetic nervous system response to pain can aid assessment, although other factors may confuse such a response. Studies of non-verbal cues show that frowns and muscle tension to be indicators of pain. The previous experience and knowledge nurses possess influence the assessment made. Studies link ignorance about pain to misconceptions which can be corrected through education. Furthermore, studies show that longevity in nursing can lead to an underestimation of pain, whereas intense personal pain experience can heighten awareness of pain in others.

2.1.1 About accepted definitions of pain

Because definitions of pain typically refer to its subjectivity, difficulty in assessment occurs when information on the subjective experience is unavailable. Pain, like comfort, is not easy to define as it is a personal and individual experience (Jaros, 1991; Ronald Melzack, 1984) involving emotional, behavioural and physical components (Charles-Edwards, 1983; Walding, 1991). There is little understood even about the physical aspect of pain as the mechanism of pain sensation remains a theory (Dolphin, 1983; Jaros, 1991; R. Melzack & Wall, 1967). Pain is universal in human experience, yet it is complex and not completely understood except by the person experiencing it (Beyerman, 1982; Schmidt, 1977). Pain has been defined in varied ways.

Margo McCaffery suggested as early as 1968 the widely accepted definition of pain as:

Pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does (McCaffery, 1968, p95).

Self-report of pain by the person experiencing it is the most reliable assessment tool, however, health professionals tend to be uncomfortable unless they can verify this against objective data (Faries, Mills, Goldsmith, Phillips, & Orr, 1991; Betty R. Ferrell, McCaffery, & Grant, 1991). Further, this definition is deficient in the situation of an intensive care patient who is unable to communicate their experience of pain because

of an altered conscious level and the presence of impeding equipment (M. Harrison & Cotanch, 1987; Puntillo, 1990; Wild, 1990).

In 1975 the International Association for the Study of Pain defined pain as, "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (Mersky, 1979, p249).

"Pain is a complex perceptual experience involving physiologic and psychologic factors" (Altice & Jamison, 1989, p49). A pain sensation is transmitted via nerve pathways to higher brain centres, it is interpreted and a behavioural response results (Haber Kern, Tyler, & Krane, 1991; Levin, Malloy, & Hyman, 1987).

The difficulty I felt trying to assess pain when patients were unable to communicate, whilst continuing to keep hold of the McCaffery definition as the ideal, led me into this project.

2.1.2 About concepts and theories of pain

At this juncture, I would like to take a step back and acknowledge that pain is a concept understood differently in other times and places. Other eras and cultures emphasise alternative views of pain. At another time, people living in a pre-scientific society dominated by religion may have considered pain to be a spiritual rather physical problem. The experience of pain would likely be seen as a punishment from the gods best cured with prayer, petition or sacrifice. On another continent, people in a tribal culture might understand pain in social terms, as a signal of a spell or conflict with neighbours and the best treatment might involve peacemaking. People living in an industrialised society probably understood pain as a signal of physical pathology best treated by a combination of drugs, surgery or other medical interventions.

Understandings of pain and how we treat it is subject to the culture and time in which we live.

Western contemporary thought recognises pain as an experience which involves a combination of physical, psychological and neurological factors. Because this more complex understanding is relatively new in terms of history, I will show the progression in Western thought in response to several proposed pain theories. There is no exclusively comprehensive pain theory, yet each available theory contributes to the total picture of pain knowledge.

2.1.2.1 Affect theory

Pain is an emotion, the opposite of pleasure, where the amount and quality experienced depends on anxiety, suggestion, past experience and learning, including cultural norms, and the meaning of pain. The internal beliefs, experience and learning about pain as well as the external culture that surrounds people varies between individuals and for the same person at different times. Even though most people will attribute a negative meaning to a pain experience, sometimes it may be viewed in a positive light. Some possible meanings that might be attached to pain include: harm, complication, disease, nearing death, limited mobility, aging, healing, punishment, to learn empathy for others suffering, as a challenge to be overcome, escape from responsibility, something to be tolerated or necessary for recovery.

Attributing meaning to a pain event can be either a conscious process or something that occurs outside of awareness. The meaning attributed to pain contributes as much to the pain experience as the physiological cause. There is a link between the meaning of pain and the purpose the pain is believed to have. The purpose of pain can provide coherence for the place of pain within life events. The meaning of the pain event opens or closes options for dealing with the pain and is related to whether or not the individual suffers (Cassell, 1985).

There was very little chance of knowing the meaning individual unresponsive ICU patients would attribute to the pain they felt, however, some individual clues may have been attainable through family members. Overall, the working assumption from ICU staff is that patients intend to live so it is also assumed patients would withstand pain in order to live.

2.1.2.2 Specificity theory

Rene Descartes' (1664/1972) concept of the body as a machine instigated new ways of thinking about pain and its causes. In his work *Treatise of Man* posthumously published in 1664, Descartes provided the following description of the specificity theory where it was simply thought that pain was directly communicated from the skin to the brain.

If fire **A** is near foot **B**, the particles of this fire (which move very quickly, as you know) have force enough to displace the area of skin that they touch; and thus pulling the little thread **cc**, which you see to be attached there, they simultaneously open the entrance to the pore **de** where this thread terminates [in the brain]; just as, pulling on one end of a cord, one simultaneously rings a bell which hangs at the opposite end.

Now the entrance of the pore or small conduit **de**, being thus opened, the animal spirits from cavity **F** enter and are carried through it – part into the muscles to serve to withdraw this foot from the fire, part into those that serve to turn the eyes and head to

look at it, and part into those that serve to advance the hands and bend the whole body to protect it. (Descartes, 1664/1972, p34-35)

In 1895, Max von Frey continued on with the specificity theory in his work with hair fibres and the sensation of touch. Von Frey used single hairs pressed against the skin of varying size to determine the threshold force needed to produce the sensation of touch. Von Frey then used probes or electrical stimulation to find sensory points sensitive to pressure, pain, and temperature. Von Frey suggested that the skin comprises minute, highly specialised areas within mosaics of four types of sensory spots: touch, cold, warmth and pain (Weddell, Sinclair, & Feindel, 1948).

The generally accepted scientific explanation of specificity theory is that pain results from a direct communication from the skin to the brain via free nerve endings (pain receptors), to A-delta and C fibres to the lateral spinothalamic tract (pain impulse carriers), then to the pain centre in the thalamus (registering of pain impulse) (Wall, 1978).

I was reasonably certain ICU nurses would hold a notion of direct causes of pain, for example, when attending to pressure care nurses ensure patients are not laying on pieces of equipment.

2.1.2.3 Pattern theory

In 1920, Alfred Goldschneider suggested that the sensations of pain or nerve impulse patterns that originated from the peripheral site of stimulation were experienced as relative to the level of stimulus, i.e. a light sensation of touch or a stronger sensation of pain to the same peripheral area of stimulus. Stimulus intensity, measured by non-specific receptors, and central calculation, within the dorsal horn of the spinal cord, are key determinants of pain. In addition, the rapidly conducting myelinated fibres inhibit conduction in the unmyelinated, pain impulse carrying fibres. Unlike specificity theory, pattern theory suggests that there are no separate systems for receiving pain, but instead the nerves are shared with other senses like touch. However, people feel pain when certain patterns of neural activity occur. Strong and weak stimuli of the same sense modality produce different patterns of neural activity. An example of touch; too much stimulation like being hit hard hurts but being caressed softly does not (Wall, 1978).

I think nurses often differentiate between painful and non-painful stimulation. Especially in ICU, a demonstration of the physiological effect can often be seen by a sudden

increase in arterial blood pressure readings in response to removing an adhesive dressing as opposed to fewer rises in blood pressure in response to bathing hygiene measures.

However, neither the specificity theory nor the pattern theory could be used to address why chronic pain continues even after the physical cause is over, why pain is experienced without a physical cause, why the location of the pain may differ from the place of the physical cause, and why the nature of pain changes over time.

2.1.2.4 Gate control theory

In 1965, Melzack and Wall claimed that the perception of pain encompasses all parts of the brain. Melzack and Wall described a gating mechanism within the spinal cord that controlled the flow of pain messages from the nociceptive fibre to the brain. Noxious impulses which travel along small fibres open the gate to allow full experience of the pain, whereas other impulses, such as cutaneous stimulation, which travel along large fibres close the gate. The centrally controlling factors, such as emotional states, motivation, learning, knowledge, and thought processes may influence the gate either way. The strength of the incoming concurrent impulses determines the response of the gate (Levin et al., 1987; McCaffery & Beebe, 1989; R. Melzack & Wall, 1965; Peric-Knowlton, 1984).

Peripheral stimulation causes impulses to travel to three areas; the cells of the substantia gelantosa in the dorsal horn, the dorsal column fibres directed towards the brain, and the first central transmission cells in the dorsal horn. The substantia gelantosa gates the nerve impulses from the periphery to the central transmission cells. Impulses along large L or A fibres close the gate whereas impulses along small S or C fibres open the gate. Brain processes can also influence the gate, such as attention opening the gate and distraction closing it.

An understanding of the gate-control mechanism underlies nurses' ways of talking patients through procedures, putting the TV on or providing background music as forms of distraction.

2.1.2.5 Endogenous mechanisms of pain inhibition theory

Enkephalins and endorphins, which are neurotransmitters within the brain, influence integration of pain and provide analgesia. The precise mechanism of action is unknown, however, it is thought that they inhibit somatosensory afferents in the dorsal horn and activate descending inhibitory pathways.

It is the neurotransmitter receptor sites that are targeted by opioid analgesia that are heavily relied on in ICU to provide pain relief.

2.1.2.6 Pain reflexes

Additional to the gate control theory are reflex and cortical responses to pain. Dolphin (1983) described responses to pain occurring at several levels of the nervous system, for example: large muscle response mediated by the spinal cord, such as withdrawal to pain; autonomic reflex controlled by the medulla, such as tachycardia; and voluntary gestures produced by higher brain centres, such as crying. Thorpe (1989) added that pain can be classified as acute, of short duration resulting from some injury, or chronic, persisting beyond the time required for healing. Thorpe also classified pain as nociceptive, noxious stimuli to peripheral receptors, or neuropathic, damaged nervous system responding unpredictably.

Assessing pain reflexes comprises part of the Glasgow Coma Scale criteria [used to assess level of consciousness] that nurses apply to patients who do not respond to sound or touch.

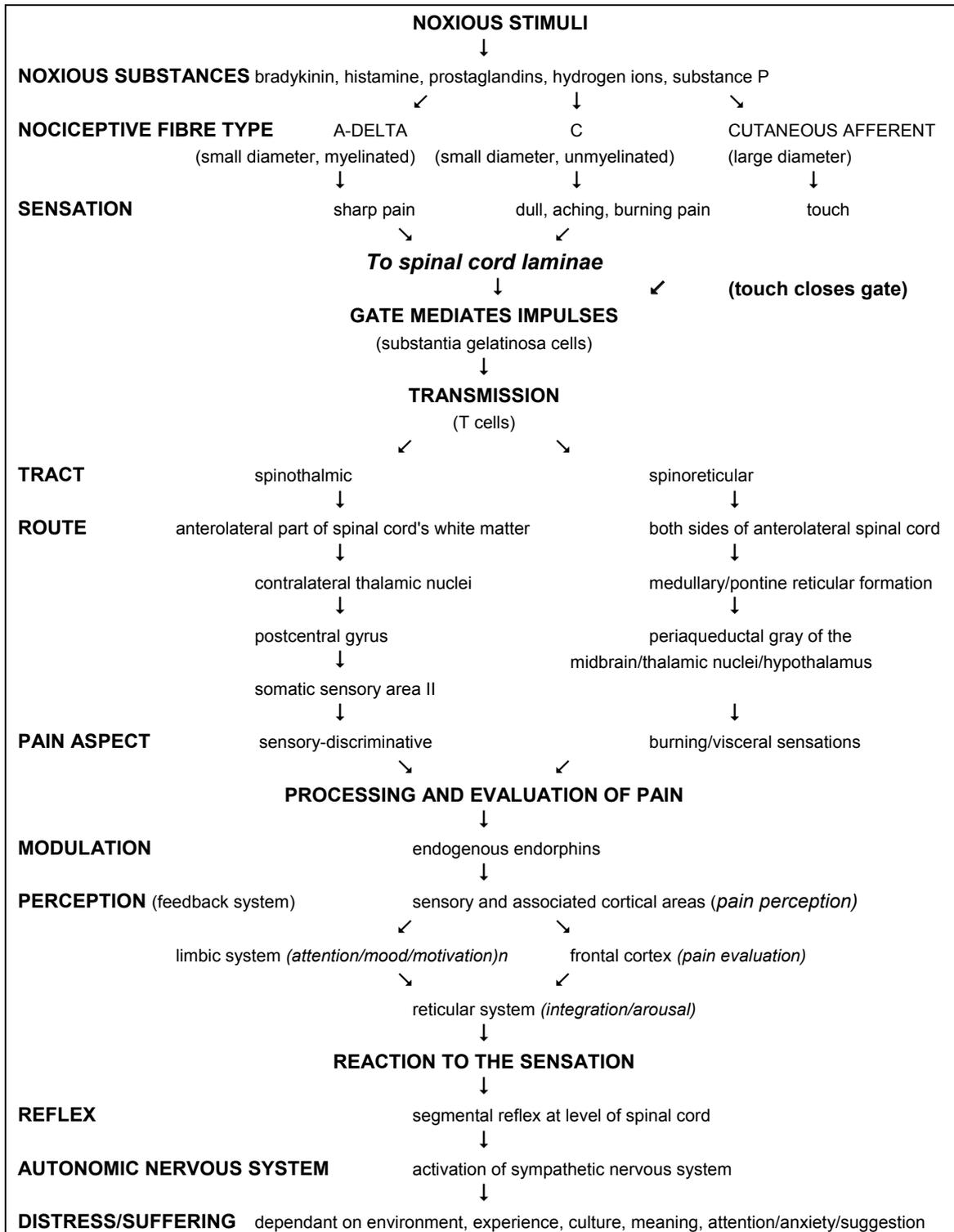
2.1.2.7 Loeser pain model

John Loeser (1982) proposed a specific model for the conceptualisation of pain where nociception, pain, suffering and pain behaviours build on each other and combine to contribute to the experience of pain. The model is depicted as concentric circles with nociception in the middle surrounded firstly by pain and then suffering and finally pain behaviours around the outside. Table 2.1.1 summarises Loeser's pain model.

Table 2.1.1 The Loeser pain model

Nociception <i>the transmission of noxious stimuli</i>	When assessing for nociception as part of the pain experience, nurses can consider what is happening within the patient's tissue that would initiate pain signals. For example, the presence of an endotracheal tube in an intensive care patient causes local pressure and irritation within the tissue of the trachea.
Pain <i>the patient's description of their pain together with observable physiological changes.</i>	When assessing pain, nurses listen to the patient's account of the experience, although, this is sometimes not possible to obtain, as in the case of critically ill patients. Physiological indicators such as sympathetic nervous activation may be indicative of pain, but other pathology may cause changes in heart rate, blood pressure and respirations making this an unreliable observation of pain (Mlynczak, 1989).
Suffering <i>emotional impact or affective response to pain.</i>	The experience of pain may cause patients to become depressed, anxious, or fearful; there can be meaning attached to the pain, losses involved or perceptions altered.
Pain Behaviours <i>the pain experience exhibited through actions and sounds.</i>	Behaviour is individual and culturally determined, therefore, a range of actions from limping, guarding and grimacing to withdrawal and immobility, and likewise with sounds from moaning to screaming, can signify pain experience in a patient (Loeser, 1982; Olsson & Parker, 1987; Paice, Mahon, & Faut-Callahan, 1991)

The literature conveyed how pain theories have evolved over time as knowledge of the physiology of pain has increased. In order to provide a more comprehensive visualisation of pain mechanism, I created the flow chart in Figure 2.1.1 to depict what I had found from the literature on pain transmission, processing and reactions evoked.



Adapted from (Hosking & Welchew, 1985; Hudak, 1986; McCaffery & Beebe, 1989; R. Melzack, 1973; Muir, 1980; Puntillo, 1988)

Figure 2.1.1 Transmission of pain sensation

2.1.2.8 Pain and cognition

Infante and Mooney (1987) define pain experience as a combination of physical, psychological and cognitive factors, thus claiming that cognitive function is required in order to perceive stimulus, categorise it and make deliberative or reflexive actions to reduce the pain. Infante and Mooney (1987, p32) then state "Patients under general anesthesia do not experience pain despite the degree of surgical trauma until they are awake and become cognitively aware of the nociceptive stimulation." Hoyt and Sparger (1984), in referring to patients in the emergency department, declare that pain is impossible to evaluate in patients' with head trauma who are unconscious. Eich et al (1985; 1985) and Hunter et al (1979) suggest that the memory for continuous pain is not reliable after twenty four [24] hours. However critical care nurses confront a dilemma when patients are unresponsive. Nurses may either assume that patients are suffering pain or they are not suffering pain. Underlying assumptions by nurses of patients' pain would be from treatment procedures or patients' disease processes. Conversely, believing that cognitive function is required to experience pain, nurses may assume patients with reduced cognitive function as a result of cerebral injury, toxemia or sedation do not experience pain. The literature has shown that pain is subjective, but when patients are unresponsive, nurses are not privy to that subjectiveness.

Nurses may consider awareness and perception to be possible in those ICU patients who have been made unconscious by treatment modalities, nevertheless, there is debate over patients' ability to experience while unconscious because little is known about the experience of being unconscious. Unconsciousness has been defined as an inability to sense, to respond to stimuli and to have subjective experiences (Dorland, 1988; Miller & Keane, 1983). Because patients with reduced level of consciousness are unable to meaningfully respond to nurses, there is argument over whether knowledge of the presence of pain is possible in those patients who are unable to demonstrate pain. If unconsciousness is assessed by response to stimuli, then in fact measurement of the mind is made through the ability of muscles (McQuillen, 1991; Sherrington, 1953) "If the muscles of speech or those involved with writing do not communicate in a fashion that can be understood, is it legitimate to conclude that there is no experience for them to communicate?" (McQuillen, 1991, p374). Long-term brain damaged patients who were unresponsive other than reflexes, eye opening and blinking have been judged behaviourally to not have cerebral cortex function (Cranford, 1988; Jennett & Plum, 1972; Tresch, Sims, Duthie, & Goldstein, 1991). The question remains as to whether pain feelings can be processed in the cortex while a person is unconscious (Christoph, 1991; Puntillo, 1990).

Specifically with the pain experience, a distinction has been made between awareness and perception (McQuillen, 1991). In favour of awareness, it has been claimed that elaborate sensory pathways in the brain go to the cortex then return to the thalamus whereas pain pathways travel directly to the thalamus and do not extend to the cortex. "Pain is the same for man [sic] and snake and you might consider that man has no pain area in the cerebral cortex because there is no need of elaboration of that sensation in the human cortex. Reflex jerking away of the injured part is sufficient." (Penfield, 1963, pp146-147) However, perception of pain could be observed through behaviours of suffering. If suffering is not observed or cannot be conveyed, is it warranted to conclude that pain cannot be perceived (McQuillen, 1991)? Instead of looking at pathways, Melzack (1984) considers pain experience to be multidimensional and complex, open to the influence of past experience, attention, meaning and other psychological input. So, although there may not be a 'pain centre' the whole brain is involved in the pain experience.

As a result of the availability of electrophysiological, anatomical, and biochemical research, the physiology of pain is better understood and effective treatment methods can be implemented. However, an understanding of the pain experience involves knowledge of the person as a whole, in addition to the individual cells and chemicals through which pain is perceived (Jaros, 1991; McCaffery & Beebe, 1989; Walding, 1991). The pain experience will always be unique to the individual enduring it; pain is intensely personal (Beyerman, 1982; Dealtry, 1992; Jaros, 1991; McCaffery & Beebe, 1989). Knowing as much as is possible about how pain works, how pain is exhibited, and how individual factors influence the pain experience, nurses can more accurately assess the pain of the patients in their care.

2.1.3 About the relationship between nursing models and pain

Conceptual models in nursing frequently omit mentioning pain or treat it peripherally. Walker and Campbell (1989) suppose that this omission is a consequence of the development of nursing models from Malsow's hierarchy of needs (1943; 1954) which include physiological, safety, social, esteem and self-actualisation needs but disregards pain.

2.1.3.1 Medical model

The medical model presumes a direct link between pain and an organic cause. Halfens and Evers et al (1990) found a description of tissue damage within patient vignettes positively correlated with an increased inference of pain by nurses.

2.1.3.2 Orem's model

Dorothea Orem's model promotes patient self care, but does not mention pain among its eight self-care deficits: air, water, food, elimination, activity and rest, solitude and social interactions, prevention of harm and promotion of normality. The focus of Orem's model is to enhance the patient's ability for self-care through one of three systems: the compensatory system, in which the nurse provides total care; the partial compensatory system, in which the nurse and the patients share responsibilities for care; and the educative-development system, in which the patient has the primary responsibility for personal health, with the nurse acting as a consultant. Orem's model relies on the idea that people have the capacity to care for themselves and are able to take responsibility for their health (Hartwig, 1991).

2.1.3.3 Roper's model

Roper's model (Roper, Logan, & Tierney, 1980) only identifies pain as a problem when it impacts on the following daily living activities: maintaining a safe environment, communication, breathing, eating and drinking, elimination, washing and dressing, controlling temperature, mobilisation, working and playing, expressing sexuality, sleeping, and death and dying.

2.1.3.4 Roy's model

Roy's model is based on the idea that change occurs continuously and patients need to adapt in order to cope with change and avoid stress. The four modes of manifestation, cause, influence and consequence may possibly cause assessment of pain to be fragmented rather than viewed interactively yet these modes may conversely have the potential to encourage a more comprehensive assessment of pain (Roy, 1984).

2.1.3.5 FANCAP

An assessment system from the Riehl interaction model (Riehl-Sisca, 1989), which is compatible with these nursing models, without the omission of pain, is FANCAP, a mnemonic standing for: fluids, aeration, nutrition, communication, activity and pain (P. H. Walker & Neuman, 1995).

Even though pain has been described as the fifth vital sign [after temperature, pulse, respirations and blood pressure] for nurses to observe (Jackson, 2002), the conceptual models constructed by nurses appear to keep nursing pain assessment as a peripheral issue.

2.1.4 About pain assessment options

The understanding of a pain experience in another person can be described as "islands of enlightenment in a sea of misery" (National Health and Medical Research Council, 1989, p1). However, variations of pain experience have been demonstrated to range from absence of pain despite intense trauma to presence of pain when there seems to be no lesion or physical disturbance. Diversity in pain experiences requires pain assessment to be based on patients' accounts of their experiences (Merskey & Spears, 1967) as the definition from McCaffery (1968) indicates that pain is what patients say hurts.

2.1.4.1 Complexity of pain experience

Health professionals often expect to observe overt pain behaviour and be verbally told of patient's pain, however, pain is viewed by many patients as a private experience which is to be concealed from others (Jacox, 1979). Therefore, an understanding of the complexity of a pain experience is an essential component of pain assessment.

The factors involved in understanding of a person's pain experience include cause, physiology, social and cultural learning, meaning of pain, past experience of pain, fear and anxiety associated with the experience, attention to the pain or distraction from it, and who has control in the situation (R. Melzack, 1973; Phillips & Cousins, 1986). These factors apply to both the person in pain and the person trying to understand the painful experience. The important factors will be discussed below, omitting the biological factors as the pain experience does not necessarily correlate with presence, absence or type of tissue damage (McMahan & Miller, 1978).

2.1.4.2 Pain experience through cultural learning and language

Culture can be considered to be the lens through which the individual perceives, understands and learns to live in the world (Lipton, 1986). Cultural learning affects expression and tolerance to pain. The norms of a culture are learned early; they dictate how to behave when in pain and where and when to express pain behaviour (Craig, 1989; Peck, 1986). Jews and Italians tend to be more vocal about their pain experience whereas Americans of Anglo-Saxon origin are usually more stoic (McMahan & Miller, 1978; R. Melzack, 1973). Levine and De Simone's study (1991) showed a tendency for males to under report pain in the presence of a female investigator. Peck (1986) claims an inclination for health professionals to reward stoicism. There is, however, a danger of stereotyping people based on their cultural background, instead, there needs to be recognition of individual variation and overlap between groups (Lipton, 1986).

Therefore, a comprehension of where the person encountering pain is coming from, and where the person trying to understand the pain episode is coming from, will aid in understanding that person's experience of pain.

In addition to the socialisation of pain behaviours, a person's culture will also determine the words used to describe pain (R. Melzack, 1973). Figure 2.1.2 is a spatial arrangement of descriptive words that are used to depict pain.

	SENSORY										
	Temporal	Spatial	Punctate	Incisive	Pressure	Constrictive	Traction	Thermal	Brightness	Dullness	Other
↓	flickering quivering pulsing throbbing beating	jumping flashing shooting	pricking boring drilling stabbing	sharp cutting lacerating	pinching pressing gnawing cramping crushing	tugging pulling wrenching	hot burning scalding searing	tingling itchy smarting stinging	dull sore hurting aching heavy	tender taut rasping splitting blinding	
increase in intensity											
	AFFECTIVE			EVALUATIVE		ANCHOR WORDS					
↓	Tension tiring exhausting	Autonomic sickening suffocating	Fear fearful frightful terrifying	Punishment punishing gruelling cruel vicious killing	annoying troublesome miserable intense unbearable	mild discomforting distressing horrible excruciating					

Figure 2.1.2 Descriptive pain words [adapted from (R. Melzack & Torgenson, 1971, p50)]

Health professionals can use the word 'pain' and be misunderstood to mean something else, likewise a patient can be coaxed to be more specific in their choice of descriptive words in order to create an improved understanding of their experience (Jacox, 1979).

2.1.4.3 Experiencing pain in relation to anxiety, attention and control

Anxiety is described to have a linear relationship with pain; an increase in anxiety will produce a corresponding increase in pain (Peck, 1986), however, studies have shown that the relationship between anxiety and pain is not always positive and unidirectional, particularly when the anxiety is caused by something separate to the pain (al Absi & Rokke, 1991). Anxiety, pain and perceived powerlessness can have a contributory effect on each other (Walding, 1991). A vicious cycle can develop where pain escalates through the addition of fear and anxiety together with sleep deprivation (Phillips & Cousins, 1986). As a result, assessment of a person's pain experience will involve understanding any associated or unassociated anxiety, fear and feelings of helplessness or lack of control.

Both anxiety and pain increase with uncertainty about anticipated pain and a belief that the situation is out of the individual's control. In such a position, the person in pain is

likely to become helpless and give up trying to take control (Peck, 1986), whereas, some control over pain stimulation can reduce stress and increase pain tolerance (Weisenburg, 1989). Studies indicate an association with the ability to control pain and variations in intensity and length of pain experience (Buckelew et al., 1990; Toomy, Mann, Abachian, & Thompson-Pope, 1991). Health personnel have traditionally taken control of the patient while ill, nevertheless, to understand a person's pain experience, the amount of control the patient perceives to have in the situation will be a factor in the pain suffered.

Attention to a painful stimulus can increase pain perception whereas distraction can decrease pain perception (Beyerman, 1982; Muir, 1980; Peck, 1986). Footballers continue to play while injured because they are concentrating on the game and not on their injury (R. Melzack, 1973). Often chronic pain sufferers use distraction every day and may not appear to be in pain (McCaffery & Beebe, 1989). The notice a person takes of the pain will influence the perception of the pain.

2.1.4.4 *Connecting meaning and past experience to pain*

There is a biological value of pain in its indication of tissue damage and the prevention of further injury (R. Melzack, 1973; Schmidt, 1977). However, the meaning placed on a situation will affect the quality and amount of pain experienced. For example, Beecher (1956), a battlefield medic in World War II, observed that soldiers with war injuries complained more about insertion of intravenous lines than the injuries they suffered on the battle field. In addition, Beecher found that for similar injuries, approximately 80% of civilians requested morphine, while only a third of the soldiers did. He concluded that the war injuries meant the soldiers could return home honourably, therefore the experience of pain was reduced. Initiation rituals also are examples of pain to which significant meaning is attached and subjects appear to be in exhilaration rather than pain (R. Melzack, 1973; Schmidt, 1977). Consequently, the response to the stressor is dependent on the perception of the stressor (Peck, 1986); there is not a direct relationship between the sensation and experience of pain, for example, an aching finger as opposed to an ache beneath the sternum. Thus, the meaning associated with the pain will be a factor in the total experience of that pain.

Meaning is sometimes learned through attitudes of parents towards their children's painful experiences which influences the way the children will react to pain in their lives. For example, if a great deal of sympathy is shown to small scratches, then the children are unlikely to grow up being stoical (R. Melzack, 1973). Similarly, pain

response can depend on how another person responds to the same stimulus, feedback or reinforcement from the environment, such as a spouse versus neutral observer (Peck, 1986).

A pain experience can have a variety of known causes or undetectable causes, however, an understanding of the experience of pain in another person depends on factors which are psychosocial. During development, the person has learned both to behave in a particular way while in pain and use certain words to describe that pain, in response to culture, family influences and past experience with pain. In the present situation of pain, anxiety, fear, helplessness and control play contributory roles in the experience, as does the meaning of the pain to the person undergoing the suffering. Finally, the amount of attention given or withheld from the pain will influence the experience of pain.

Understanding pain in children is even more limited because of their narrow range of previous experience with pain. Their cognitive understanding of and emotional response to pain are different from that of adults. For example, children lack time concepts giving them a perception of the current pain going on forever and no understanding of the good consequences of a painful procedure. In addition, children tend to use words such as "ouch" and "hurt" whereas adults have over a hundred words to express pain. Studies have shown a wide variation in understanding children's pain and myths continue leading to under treatment of children's pain. Pain assessment methods such as a range of faces from happy to sad and colouring-in techniques help to define the pain experience in children (Eland, 1986; Haberkern et al., 1991; Mahan & Strelecky, 1991; Murrell, 1992; Price, 1991).

Researchers, such as Baer et al (1970), Lander (1990), and Mason (1981), have found that the more experienced the nurse, the greater the correlation with underestimating patient's pain, whereas, those with less nursing experience inferred the greatest suffering. Life experience and cultural upbringing, values, expectations and personal experience with pain all influence nursing pain assessment.

Hoyt and Sparger (1984) state that pain assessment is significantly affected by the health worker's values and expectations. Life experiences and cultural upbringing are also implicated as influencing factors (L. L. Davitz, Davitz, & Higuchi, 1977) Holm et al (1989) specifically found that the intensity of a nurses's personal experience with pain influenced subsequent assessment of pain in patients.

Longer experience as a nurse tends to correlate with underestimating patients' pain. This phenomenon is thought to be linked to exposure causing a hardening in order to protect the nurse from emotional drain (Baer et al., 1970; Choiniere, Melzack, Girard, Rondeau, & Paquin, 1990; Lander, 1990). Mason (1981) found nurses with less than 1 year's experience inferred more pain than those with 6-10 years experience.

The response people have to pain in their lives can be influenced by the meaning they attach to the pain as well as their learned behavioural reaction which is culturally determined (Muir, 1980).

2.1.4.5 The inaccuracy of independent nursing assessment of pain

Even though nurses are the members of the health team who are in most contact with the patient experiencing pain and so are in a good position to contribute to pain management (Betty R. Ferrell et al., 1991; Infante & Mooney, 1987; Peric-Knowlton, 1984), it is concerning that studies have shown nurses tend to underestimate pain in patients (Donovan, Dillon, & McGuire, 1987; Lisson, 1987; Paice et al., 1991; Rankin & Snider, 1984). Further, research by Watt-Watson (1987) found that a systematic approach to pain assessment was rarely used.

Paice et al (1991) examined the relationship between patients' descriptions of pain and the perspectives of both nurses and doctors. Using random sampling and basing the measurements on the Loeser pain model, Paice et al found no correlation between nurse/patient, doctor/patient, or nurse/doctor in pain intensity scores. Paice et al claimed that accurate pain assessment by health workers continued to be lacking based on the McCaffery definition.

However, Harrison (1991) believed that there may not have been a discrepancy from health workers misjudging patients' pain but in patients' reports of pain. Harrison attributes the discrepancy between health workers' and patients' reporting of pain to patients overemphasising or hiding pain from health workers. However, this concept contravenes the definition of pain as 'whatever the person says it is', which recommends nurses listen to patients in order to assess pain. The patient's evaluation of pain is therefore the standard by which to measure the accuracy of the health worker's assessment.

Time spent on teaching pain related topics during initial nurse education in the USA has been found to be sparse (Graffam, 1990) resulting in a lack of knowledge

regarding physiology of pain, variations in pain response and pain management options (Sheredy, 1984; Wood, Bailey, & Yates, 1982; Wood & Dodge, 1982). Fallacies exist regarding patient credibility, pain tolerance and addiction to analgesics (Cohen, 1980; McCaffery & Beebe, 1989). In several research studies, education has had a positive effect on attitudes towards pain, actual assessment and documentation (Camp-Sorrell & O'Sullivan, 1991; Davis, 1988). Albeit these studies only measure short term effects.

Experimental research by Moss and Meyer (1966) looking at the interaction between the nurse and the patient immediately preceding measures to address pain, showed a significant difference in pain relief obtained when the pain experience and pain relief methods were discussed with the patient. Experimental research by Diers and Schmidt et al (1972) approached patients in pain in the three different ways outlined in Table 2.1.2, and measured the effect on the patient. The study found that a holistic nursing approach [approach one] impacted positively on pain relief obtained.

Table 2.1.2 Three pain approaches [adapted from (Diers et al., 1972)]

<i>Approach</i> one	<i>Person</i> feeling thinking doing	<i>Pain</i> psychosomatic phenomenon with physical, emotional and cognitive components
two	thinking doing	partly physical entity with analysis of cause helping pain relief
three	doing	physical sensation

2.1.4.6 Lack of documentation

Even though multiple tools are available, documentation of pain remains poor according to studies done by Donovan et al (1987) and Camp and O'Sullivan (1987) where entries in patient notes were totalled and compared with the patient's view for accuracy. Separate research by Fox (1982) and Bagley et al (1982), based on medical record audits, also found documentation of pain absent from patient notes. In an oncology setting, Camp (1988) researched the correlation between patient reports of pain and documentation by nurses, finding there to be both insufficient documentation and poor agreement between the nurse and patient as to the pain experienced.

Various tools have been developed to aid in assessment and documentation of pain as outlined in Table 2.1.3. Ranging from assorted continuums, describing no pain to worst pain, to lengthy questionnaires, these tools assume a capability of patient response (Faries et al., 1991; McCaffery & Beebe, 1989; Thorpe, 1989).

Table 2.1.3 Reviewed pain tools

<i>Visual analogue scale</i>	The visual analogue scale displays no pain at one end and intolerable or unbearable pain at the other end. Graduations are eliminated and misinterpretation of words reduced. Patients locate their pain as a point on the line between the two extremes.
<i>Numerical Scale</i>	A continuum is used with 0, representing no pain, at one end and 10, portraying unbearable pain at the other end. This scale allows for sensitivity and avoids misinterpretation of descriptive words. Herlitz and Richter et al (1986) used this scale to quantify pain in coronary care patients on admission and second hourly after that, noting trends of amount of pain correlating with size of infarction and overall reduced pain over time. Bondestam and Hovgren et al (1987) also used this scale with coronary care patients, comparing the numbers obtained with nursing assessment. Bondestam and Hovgren et al found that nurses underestimated or overestimated patients' pain 43% of the time.
<i>Descriptive Scale</i>	Along a continuum, words describing pain range from none, mild, moderate, severe, to unbearable. The tool is easy to use but the words are limited and open to misinterpretation.
<i>Coloured Chart</i>	Researching in New Zealand with an aim to enable patients to be involved in their pain management, Tuffnell and Clarke (1988) developed a coloured pain scale based on Stewart's research (1977). Stewart's coloured pain chart moved from yellow, signifying no pain, to orange then pink, moderate pain, to red and finally black, extreme pain. Stewart found that people mostly chose red to depict their pain. Current coloured pain scales vary in the range of colours used.
<i>Pain faces scale</i>	More familiar to paediatric nurses is the pain faces scale which depicts emotions from happy to sad. Children can use this chart to pick a face to match their pain experience.
<i>McGill Pain Questionnaire</i>	Developed at McGill University by Melzack and Torgerson (1971), the McGill Pain Questionnaire, also known as the McGill Pain Index, is a scale of rating pain that can be used for a more comprehensive pain assessment. This questionnaire includes a drug and treatment history as well as response of the patient and influencing factors. In addition, words used to describe pain are categorised according to their intensity and into sensory, affective and evaluative groupings. [see Figure 2.1.2] To use the questionnaire, nurses circle words in each group that describes the patient's pain. The words are scored, the higher the score the more pain is a problem for the patient. The aim is to describe both the quality and intensity of patients' pain. Difficulties exist with interpretation of words and categorising them, rendering the tool subjective. A small study by Berker and Hughes (1990) of the introduction of such a chart into a coronary care unit resulted in an increased awareness of patient feelings, reduction in assumptions, increase in continuity of care and aided patient verbalisation regarding their pain.
<i>Pain Characteristics/ Disruptiveness</i>	Nemni (1988) developed a measure of the quality and intensity of pain through the use of graded word lists. A disruptiveness scale was also developed which displays a graded statement list, for example, 'keeps me awake' or 'makes me tired'.

Table 2.1.3 (continued) Reviewed pain tools

<i>Pain Assessment Tool</i>	Developed by McCaffery (1989) with additional components from McMillan and Williams et al (1988), this tool addresses affective, behavioural and sensory components of the pain experience. Faries and Mills et al's pilot study (1991) found this tool was consistently not used by the nursing staff and suspected that duplication of charts caused under-usage. Peric-Knowlton (1984) reported that pain relief was improved when the patient was involved in pain assessment and management.
<i>Pain Flow Sheet</i>	McMillan and Williams et al (1988) constructed and verified the validity of the pain flow sheet used to document pain assessment and management on an ongoing basis. Faries and Mills et al (1991), after treating one group of oncology patients traditionally and the other using the continual assessment of this tool, found that the systematic tracking of pain resulted in improved pain management.

Thorpe (1989) and Harrison (1991) both advise that the key to which tool to choose depends on what the patient comprehends and relates to the best. Although, nursing assessment of pain is thought to be hampered as a result of infrequent use of the above tools (McGuire, 1984), Guyton-Simmons and Mattoon (1991) found that expert nurses in the critical care environment were very efficient in selecting information regarding patients' pain through the use of directed interaction rather than the use of cumbersome and detailed tools.

2.1.4.7 The ICU pain and sedation chart

Pain rating tools, as previously described, can sometimes be used with conscious, intubated patients but are not appropriate for the majority of critically ill patients (Puntillo, 1988).

The ICU Pain and Sedation Chart [see Appendix O] was in use at the beginning of this study to aid in assessment and documentation of pain in critically ill patients. Nurses assessed patients' pain during certain procedures, such as coughing and movement, and documented a pain level from 1-nil to 4-severe. Nurses decided what level of pain patients were experiencing, as analgesia was ordered to titrate to 2-a mild level of pain during procedures. However, there were no guidelines for this assessment and therefore I thought it was subjective and variable. The participants of this study referred to the chart presented in Appendix O. Currently, patients' progress in ICU is documented on a flow chart which has a space for recording pain level each hour. The key displays the same concept of pain scoring however the numbers have changed; 0-none, 1-mild, 2-moderate, 3-severe.

2.1.5 Nursing pain assessment in ICU

The critically ill patient typically cannot verbalise their pain, because of impeding equipment such as endotracheal tubes and decreased level of consciousness. Previously mentioned pain tools become unsuitable. With a good understanding of the physiology of pain together with remembering assessment of pain in awake and communicative patients may help nurses to conceptualise assessing pain in unconscious patients.

Puntillo (1988) found that patients in ICU have substantial pain, either from their illness or diagnostic and treatment procedures. The environment of ICU adds to the pain experience through noise, light, lack of sleep and the presence of anxiety. The nurse at the bedside, because of proximity, is in the best position to assess the patient and to make decisions regarding pain relief measures based on the assessment data gathered (M. Harrison & Cotanch, 1987). Mlynczak (1989) suggests that pain assessment of trauma patients is based on quantifying what the patient says, quantifying pain behaviours, and observing physiological pain parameters. Ferrel et al (1991) studied how nurses make clinical decisions about pain. Although they approached the topic from an oncology perspective, Ferrel et al's conclusions, which embody frequent nursing interaction with pain, including assessment and the sources of information used, management, incorporating barriers to effective pain relief, and ethical conflicts, are applicable to intensive care nurses.

Several studies have described the physical environment of ICU as far from pleasant for patients because it is set up for saving the lives of those who would otherwise die. Patients in ICU usually need close observation or monitoring and treatment relying on technology to assist physical function because their own body systems are in some degree of failure. The lights are always on, although the brightness may vary it is difficult to know when it is day or night, it is usually cold, and there is always noise; people talking, machines alarming, telephones and radios, clatter and movement. Patients are constantly disturbed from their rest (Clark, Fontaine, & Simpson, 1994; Glide, 1994; Halm & Alpen, 1993; Heath, 1989; Kido, 1991; Stanton, 1991; Turnock, 1989; Wilson, 1987). Nurses working in acute care areas are comfortable with technical equipment and base nursing assessment on the data collected. The patient in the bed also receives direct observation, although there are many barriers in assessing a patient who cannot respond.

Implementing the necessary procedures and treatments to keep ICU patients alive often causes restricted movement and therefore discomfort or pain which is usually felt greater at night being exacerbated by sleep deprivation (Stanton, 1991). Patients have remembered feeling relief after their position was changed, although the actual turning was frightening and uncomfortable (Heath, 1989). Sometimes patients' posture is positioned comfortably but the tubes and connections are pulling (Johnson & Sexton, 1990). Hall-Lord, Larsson and Bostrom (1994) found patients experienced distress in response to nursing procedures. In ICU, suctioning [the suction removal of sputum] is a common and frequent nursing procedure that patients have remembered to be distressing, describing it as painful, especially when the endotracheal tube is moved during the procedure (Earl, 1979; Henschel, 1977; Turner, Briggs, Springhorn, & al., 1990), and extremely upsetting when experiencing the feeling that they cannot breathe (Johnson & Sexton, 1990). Suctioning also causes pain at the incisional sites of surgical patients (Puntillo, 1990).

The unpleasant physical environment of ICU can cause sensory deprivation from reduced variety of sensory input or sensory overload when several sensory effectors act together at greater than normal levels of intensity. Studies of awake patients in ICU found that patients feel isolated (Moore, 1989) and experience problems such as nightmares, pain, immobility, lack of communication and a lack of privacy (Ballard, 1981; Chyun, 1989; Daffurn, Bishop, Hillman, & Bauman, 1994; Dorland, 1988; Dracup, 1988; Simpson, Armstrong, & Mitchell, 1989; Stanton, 1991; Wilson, 1987). The content of nightmares usually depict imprisonment, torture and depersonalisation (Asbury, 1985). Patients' experience of the care they receive in this environment has been compared to experiencing torture (Dyer, 1995a, 1995b). Sleep deprivation, anxiety and pain constitute a vicious circle which entangle the ICU patient (Stanton, 1991), contributing to the development of critical care psychosis and personality disorders (Christoph, 1991).

Patients are thus subjected to a great many stressors within the intensive care environment, one of which is the experience of pain (Puntillo, 1990). As has been shown previously, the subjective nature of pain depends on a total patient picture and can only be what the patient conveys (McCaffery & Beebe, 1989). However, intensive care patients often cannot communicate as a result of being intubated and sedated or because of decreased level of consciousness for a variety of reasons (Puntillo, 1990). Therefore, problems exist in defining what pain the patient is experiencing, determining

how this experience is communicated to the nurse, and discovering on what basis the nurse assesses pain in these patients.

Physical discomfort accompanies many illnesses, injuries and treatments within the sphere of intensive care. Studies that focus more specifically on the pain that ICU patients are likely to experience, and sometimes remember, claim that this pain would be substantial (Ballard, 1981; M. Harrison & Cotanch, 1987; Jones, Hoggart, Withey, & Donaghue, 1979; Puntillo, 1988, 1990; Tosch, 1988). For example, discomfort could range from the severe headache of neurotrauma to routine chest physiotherapy that intubated patients receive; or environmental noise and light resulting in a lack of sleep with the presence of anxiety can add to the pain experience (Chew, 1986; Christoph, 1991; Simpson et al., 1989; Stanton, 1991).

Studies from the patient's perspective point to the experience of pain being a significant worry during their stay in the intensive care unit (Ballard, 1981; Jones et al., 1979). Chew (1986) studied memory of intensive care experience and found poor sleep caused by pain and movement to be the most common complaint. Simpson, Armstrong and Mitchell (1989) also found pain as the most frequently reported stressor in one study of fifty nine patients after a stay in critical care. In Puntillo's study (1990), sixty three percent of patients remembered moderate to severe pain while in critical care. However, Puntillo fails to document the conscious state of the sample during their time in ICU. Finally Tosch (1988) found eight of fifteen head injured adults reported memory of happenings during coma. Common memories were of painful touch and other unpleasant sensations.

Being seriously ill can cause perceptual changes resulting in negative experiences for these patients. Experiencing sensory input such as smell, sight and hearing during unconsciousness can be unusual because there is widespread cerebral cortex and reticular activating system dysfunction in unconsciousness so that the brain cannot take in and interpret stimuli appropriately (Plum & Posner, 1980; Wong, Wong, & Demdster, 1984). Both drug induced sedation causing drowsiness and the need for mechanical ventilation inhibit verbal communication (Hagland, 1995). Thoughts of being buried alive and feeling panic during pharmacological paralysis, if not at the same time receiving psychotropic drugs, are upsetting and can cause post traumatic stress syndrome (Perry, 1985). Some drugs or confusional states may cause hallucinations (Bergbom-Engberg & Haljmae, 1988). Memories of such experiences have been documented, for example, a nurse who was a patient in ICU remembers

periods of lucidity, hallucinations and loss of time (Ruiz, 1993). Another nurse remembers when she was unconscious while intubated for asthma being able to hear and feel but unable to communicate although she was internally screaming and crying (Rhiannon, 1992). The resulting feelings of discomfort and frustration may lead ICU patients to feel dehumanised (Bergbom-Engberg & Haljamae, 1989; Pearce, 1988) .

Trauma, disease or poisoning are the usual causes of the massive failure of physical function that brings patients to ICU, however, looking at these patients as they lie in their beds does not give nurses a clear indication of patients' experiences. We may see anything from horror to peacefulness (B. R. Ferrell, Eberts, McCaffery, & Grant, 1991; Infante & Mooney, 1987; Peric-Knowlton, 1984). Some unconscious patients are able to hear and understand well, as is shown when they recount their experiences on gaining consciousness (Shuldham, 1984), whereas other patients do not recall memories because of trauma, especially head trauma, or from receiving drugs such as barbiturates (Bergbom-Engberg & Haljamae, 1988). Schnaper (1975) was the first to look at memories of the experience of being unconscious. He interviewed sixty eight patients who had recovered from unconsciousness following trauma, and found forty three could not remember being unconscious, and another eight were initially amnesic but were able to remember later. Tosch (1988), replicating Schnaper's study, talked to fifteen patients. She found eight patients were able to remember experiences while unconscious. Four of these patients found hearing reassuring voices and receiving physical touch to be helpful. De Giorgio and Lew (1991) suggest that to be conscious involves a functional cerebral cortex and brainstem, especially the reticular formation which connects the thalamus, limbic system and cerebral cortex. This reticular formation integrates sensory stimuli and either arouses or inhibits the thalamus and cerebral cortex. However, Barrie-Shevlin (1987) claims the reticular activating system continues to transmit sensory messages to the cerebral cortex even when patients are under anaesthetic, or in deep sleep, whether induced or not.

Because nurses cannot know the experience of a patient while they are unable to communicate in any purposive way, sometimes memories of patients who have survived intensive care and can communicate, give nurses clues to use for current patients. Some of these accounts have been recorded through research. Most studies of patients' memories of their ICU experience do not specify the conscious level of these patients while in ICU nor what medication they received which may have contributed to amnesia (Ballard, 1981; Dorland, 1988; Simpson et al., 1989; Wilson, 1987). Even though patients may remember their experiences of pain after leaving

intensive care, at the time, critically ill patients' experiences of comfort or pain are difficult to assess when the option of communication is unavailable. Nurses frequently guess when critically ill patients experience pain (Bernauer & Yeager, 1993). I was interested in the basis of this guess.

Noticing physical indicators of pain is recommended when intensive care patients are barred from natural forms of communication, as a result of a reduced level of consciousness caused by injury, illness or treatment, and therefore are often unable to tell nurses that they are experiencing pain (M. Harrison & Cotanch, 1987; Puntillo, 1990; Wild, 1990). The literature suggests that in the case of unconscious patients, nurses look for restlessness, agitation, sweating, pallor grimacing or moaning (Kaiser, 1992), tachycardia, tachypnoea and hypertension as signs of pain (Crippen & Ermakov, 1992; M. Harrison & Cotanch, 1987; Wild, 1990). Although pain stimulates the autonomic nervous system to effect such changes in vital signs as listed above, Mlynczak (1989) posts a reminder that critically ill patients may also have pathology as a confounding cause of such pain cues making the physiological parameters rather unreliable. For example, tachycardia can indicate hypovolaemia or sepsis as well as pain (Mlynczak, 1989). Bondestam et al (1987) discovered that nurses overestimated the patient's pain when heart rate and blood pressure increased. In Puntillo's descriptive study (1990), patients who could not speak described a number of behaviours they used in order to communicate their pain to the nurses. These included facial expressions and hand or feet movement. Other patients indicated that they believed the machines were able to communicate their pain for them. Behavioural scales have been validated by a comparison between behaviour observed and self-report of pain from the patient. These scales list behaviours, such as gross body movements (restlessness, tenseness, rubbing), facial expressions (frowns, grimaces), sounds (moans, groans, sighs, cries), perspiration and nausea as observable demonstrations of pain experience and intensity (Chambers & Price, 1967; LeResche & Dworkin, 1988; Mateo & Krenzischek, 1992). However, several studies have examined the correlation between patient's self-report of pain and nurses' observation of non-verbal behaviours and found it to be poor. As a result, Teske, Daut and Cleeland (1983) advise that caution should be exercised when judging a patient's pain using pain behaviours only (B. R. Ferrell et al., 1991; Infante & Mooney, 1987; Peric-Knowlton, 1984). Research results show that nurses tend to both underestimate pain in patients (Donovan et al., 1987; Lisson, 1987; Paice et al., 1991) and under-treat pain (Marks & Sacher, 1973; Slack & Faut-Callahan, 1991). Nurses need to note physical changes in patients in the light of knowing each patient and their particular pattern of

behaviour and vital signs. Pain should be assumed unless proved otherwise (Dyer, 1995b).

Inconsistency between what patients experience and what nurses think patients experience may occur as a result of individual characteristics of nurses and patients. Davitz and Davitz (1980) consider that nurses infer suffering rather than observe it. Therefore, nurses' own experiences and beliefs determine inferences made about pain. Studies that have matched patient or nurse characteristics with pain assessment and inference of suffering have found nurses think more pain is experienced when they have personally experienced pain themselves or are new to nursing or if the patients are younger or poorer or displaying culturally appropriate behaviour (Lois L. Davitz & Davitz, 1980; L. L. Davitz et al., 1977; Dudley & Holm, 1984; Holm et al., 1989; Mason, 1981). I wondered how nurses' experiences impacted on the care they gave patients in this situation.

In Puntillo's study (1990), some patients thought that nurses should have presumed they had pain. A speculation of pain on the basis of known nociceptive stimuli may be the only option left when nurses assess paralysed patients. I wondered what knowledge nurses based their idea of what would cause pain. Patients' recall of assessment of pain by nurses in a study by Puntillo (1990) consisted of nurses lip reading, offering writing material, noticing facial expression or other behaviour, or just assuming it hurt. Expecting pain because of the illness or injury the patient is enduring may be the only indicator on which to rely, for example, in the paralysed patient (Christoph, 1991).

Amongst the physical cues delineated in the literature, I was particularly interested in facial expression because I thought knowing the facial expression of pain would allow nurses to interpret any expressions that might be seen on unresponsive patients' faces. Various studies have linked non-verbal cues, such as behaviour and facial expression to intensity of pain experience. Mateo and Krenzischek (1992) tested a modified version of the Chambers and Price (1967) pain rating scale on patients recovering from general anaesthesia, comparing nurse observations of the patient with self-report of pain by the patient when more conscious. They found that facial frowning, grimacing, muscle tension and groaning sounds to be significant indicators of pain. Le Resche and Dworkin (1988) used the Facial Action Coding System developed by Ekman and Friesen (1978) to code facial expressions during video-taped painful procedures. The researchers had informed consent from the subjects. The painful expression shows the

facial action units of lowering the brow, tightening the skin around the eye, closing the eyes, raising the upper lip, stretching the lips horizontally, and opening the mouth.

There was a void of local information on the particular problem of unresponsiveness and pain in ICU at the time of procuring literature. Not being able to describe the current 'state-of-the-art' practice, I considered that my study was uncovering 'grass roots' or 'at the coal face' of ICU nursing practice from the nurses' perspectives.

2.1.5.1 Using the Loeser model to frame up pain assessment in ICU

From my journey through the literature, I resonated best with the Loeser model as a way of logically organising the process of pain assessment by nurses asking questions about the four areas. Table 2.1.4 contains the suggested questions for nurses to consider when using Loeser's framework.

Table 2.1.4 Pain assessment using the Loeser model

NOCICEPTION	What is happening in the tissues to initiate pain signals? (infection, incision or pressure)
PAIN	How do you know the patient is in pain? (subjectively via the patient's description or objectively via your observation of restlessness, BP and Pulse changes)
SUFFERING	How is the pain affecting the patient emotionally? (anxiety, depression or potential loss)
PAIN BEHAVIOURS	What is the patient doing that tells you they are in pain? (either verbally or nonverbally, for example, moaning or grimacing)

2.1.6 About nurses working with doctors

Doctors are implicated with nurses in ICU when dealing with pain in unresponsive patients by virtue of their prescribing of analgesia. Inherent differences in nursing and medicine has meant the relationship between nurses and doctors has problematic elements. Traditionally, nursing attracted untrained, poor women who, dominated by church and army doctrines, were required to be altruistic, selfless and devoted. On the other hand, medicine gained status and power, through gender, education and money, (Alpert, Goldman, Kilroy, & Pike, 1992; Benner & Wrubel, 1989; Campbell-Heider & Pollock, 1987; Darbyshire, 1987; Hand, 1991; Keddy, Gillis, Jacobites, & al., 1986; Keddy, Jones-Gillis, Jacobs, Burton, & Rogers, 1986; Lumby, 1991) and its members were expected to be 'captains of the ship' (Meighan, 1991, p64). This pattern of dominance and subordination, reflecting the power and gender dynamics in society, was said to have begun when lay female health work ceased (Ashley, 1976, 1980;

Ehrenreich & English, 1973; Lovell, 1981; Reverby, 1987). Nursing is still somewhat considered to be women's work. In a society that values individualism and autonomy, the 'caring' of nursing can be invisible and devalued (Benner & Wrubel, 1989). Interestingly, Mackay, Matsuno and Mulligan (1991) found that doctors who had been in another career previous to medicine had less problem relating to nurses. The power dynamic between doctors and nurses works itself out in patterns of communicating where, as Stein (1967) in first describing the 'doctor/nurse game' explained, nurses may make suggestions, recommendations and decisions about patient care as long as it appears that the initiatives have come from doctors. Believing that they hold the ultimate authority and responsibility, inexperienced doctors perceive more communication problems with nurses than more experienced doctors and are more likely to be involved in playing the 'doctor/nurse game' with experienced nurses. When nurses and doctors have known each other over time, communication becomes clearer because there is an unsaid recognition of each other's abilities (Alpert et al., 1992; Benner, Tanner, & Chelsa, 1996; MacKay et al., 1991). MacKay, Matsuno and Mulligan (1991) found nurses with post-basic qualifications perceived less communication difficulties with doctors. The skill of 'making a case' (Benner et al., 1996, p287) is used by expert nurses who have developed adeptness for negotiation through the stages of skill acquisition (Dreyfus & Dreyfus, 1986). Benner et al explain that 'making a case' involves presenting information to doctors in a format that highlights the most important points and shows the importance of and interrelatedness between facts. Whereas inexperienced nurses may not present information in a form which doctors expect and thus may not be heard. More recent literature suggests that nurses are still keen to avoid conflict with doctors, (Benner et al., 1996; Meighan, 1991) so the game continues, unless occasions occur when nurses decide to quit playing (Alpert et al., 1992; Dayton, 1992).

Nurses establish credibility through competence and being able to communicate clearly with doctors, (Benner, 1984), however, alliance to differing models of knowing muddies this communication (Benner et al., 1996; Eubanks, 1991). Currently, scientific knowledge, the domain of medicine, is revered by our society. Whereas clinical knowledge and 'knowing' the patient, the domain of nursing, holds lower status (Dreyfus & Dreyfus, 1986; Schon, 1983). It has been noted that clinical know-how can also be present in experienced doctors (Benner et al., 1996). Although this clinical knowledge, recognising patterns and picking up changes, together with 'knowing' the patient, can be the first hint of what is going on for the patient, both nurses and doctors give more value to hard data; those things that are measurable (Benner et al., 1996).

Nurses and doctors also focus on different areas of patient care; doctors treat pathology whereas nurses also deal with human responses to pathology (White, 1989). The medical model views diseases as self-contained things that can be diagnosed, the cause discovered and specific treatment given. The Descartes mind/body split is upheld in medicine, whereas nurses tend to see a more complete view of the whole person (Walters, 1992). However, “No profession can morally or legally shrug off the human responsibility to use their knowledge to the best of their ability in the situation. The worth and dignity of their work require that nurse and physician draw on their own and other’s clinical wisdom, expertise and science when a patient’s life is at stake, regardless of the social conflict that may ensue.” (Benner et al., 1996, p298) The patient wins when doctors and nurses talk clearly with each other (Alpert et al., 1992).

2.1.7 About pain management options

Characteristic of health workers in ICU is their prioritising of life threatening situations over dealing with pain. Pain assessment and management may indeed be delayed to aid in diagnosis of pathophysiology (Puntillo, 1988; Stanton, 1991). Unrelieved pain has a significant impact on patient wellbeing, resulting from increased sympathetic response by the nervous system. Release of catecholamines increases heart rate and peripheral resistance, which together elevate blood pressure. Myocardial work rate expands increasing its need for oxygen. Pain may splint the diaphragm thus limiting lung expansion and reducing available oxygen in the bloodstream. Obviously, such stressors on an already critically ill patient are unwarranted (O’Gara, 1988; Slack & Faut-Callahan, 1991).

Pain can be demanding, attention grabbing and totally disruptive (Schmidt, 1977). It depends on who is in control. Many pain management techniques exist for the control of pain, and each has a basis for its effectiveness founded on the scientific knowledge and theories on pain that are available. The most productive pain relief measures use a combination of pharmacological and nonpharmacological methods (McCaffery, 1990), therefore, independent nursing interventions can be adjuncts to pharmacological therapy in the treatment of pain (Altice & Jamison, 1989).

The three distinct entities that influence the gate to close thus blocking the transmission of pain messages to the brain are large fibre stimulation, central thought processing, and the endorphin pathway. The most common pain management technique in ICU, narcotic analgesia, follows the endogenous endorphin pathway and blocks the gate through modulation of the impulse, that is, there is an alteration or change in

processing or evaluation of the impulse, making it less painful or more easy to deal with (McCaffery & Beebe, 1989). ICU nurses frequently administer narcotic analgesia but do not often consider adjunctive therapy for the relief of pain which relies on stimulation of the large diameter, cutaneous afferent nerve fibres, which also close the gate. Thirdly, perception of the pain can influence the gate to either close or open, that is, the patient who believes that suctioning will aid in quicker recovery, for example, experiences less pain during the procedure than the patient who has no warning of the procedure or does not believe it will.

Distraction draws attention away from pain possibly by redirecting cortical efferent pathways (Puntillo, 1988), whereas, patient controlled analgesia uses the opiate receptor sites to alter the perception of pain and gives the person control in the situation (Halliwell, 1992). Perceived control in the individual experiencing pain will influence both distraction and patient controlled analgesia as pain control techniques (Johanson, Magnani, Chan, & Ferrante, 1989; VanDalfsen & Syrjala, 1990)

Undertreatment of pain is said to be a current problem (B. R. Ferrell et al., 1991). Although doctors order analgesia, nurses often decide when and how much to administer (Betty R. Ferrell et al., 1991). Puntillo's study (1990) found there was no correlation between the amount of morphine administered to cardiac surgical patients and their recall of the intensity of pain they experienced. Underdosage of analgesia can result when nurses are concerned about addictive and side effects (Cohen, 1980; Marks & Sacher, 1973; Mather & Phillips, 1986). Mateo and Krenzischek (Mateo & Krenzischek, 1992) detected a hesitation by nurses to administer analgesia initially post anaesthesia, resulting from concern of the side effects of the medication and a perception that the patients were not in pain because they would drop back off to sleep. The actual process of admission of a patient to the recovery area was found to take precedence over administration of analgesia.

When managing pain, ICU nurses can employ comfort measures to eliminate where possible, the presence of noxious stimuli. For example, frequent change of position and limiting unnecessary contact with restrictive equipment are simple measures that can lessen the pain experienced.

2.1.8 Summary

The pain experience is a complex and individualised phenomenon known only completely to the person experiencing it, whereas the person trying to understand it can only come close to comprehension. Because pain is a regular occurrence encountered during the practice of nursing, pain needs to be understood by nurses. Especially in the setting of intensive care, the phenomenon of pain renders a special set of problems as technical apparatus impedes the patient conveying pain messages to the nurse. Knowing how pain works and how it can be exhibited, nurses can more accurately assess pain in patients in their care. Nurses must believe the patient's account of pain, though, when it is impossible to obtain, educated guesswork comes into play through the reliance on physical signs and behavioural clues. Owing to the detrimental effects pain has on patient outcomes, taking into consideration a history of nurses underestimating and therefore under-treating pain and patients remembering pain while seemingly unconscious, we may reasonably conclude that there is room for improvement in pain management. Updating nurses' knowledge with the latest pain information would help pain assessment.

Knowledge of pain has increased over recent years thanks to the efforts of researchers such as those reviewed here. On the whole, the research reviewed took place in the USA, both inside and outside the acute care area. The field was open for the development of research into acute care pain assessment by nurses, especially in the Australian context. Most research reports contained no reference to the ethics of the study. None referred to ethical review boards, occasional mention was made to sources of funding. A few stated that informed consent was obtained, especially if the procedure was questionable (applying pain and video-taping facial expression), but did not detail the information given nor the option for subjects not to participate. The research reports kept data anonymous by referring to locations within the country but not including specific names of places or people. The literature presented here established the importance of my research interest as a major concern of many writers and researchers: a concern which has caused enormous effort to be expended but not giving a lot of direction for the "way forward".

The literature reviewed in this section reflects my search for objective information on assessing and managing pain in unresponsive ICU patients and as such represents the foundational knowledge on which I commenced the study. On not finding the instructive answer I sought, yet with a greater understanding of the interaction of pain and

patients, I embarked on this research project to fill a void in the literature. Specifically, I wanted to address the lack of information on unresponsive patients. Additionally, I wanted to undertake this research project in a way that reflected the complexity of actual nursing practice and thus would obtain inclusive, holistic information that covered the realities of nursing practice.

Based on knowledge of how pain was currently understood, including physiology and cognition, I was better able to conceptualise possible pain experiences in unresponsive patients but I wanted to understand nurses' response to the complex factors involved. The next task of the project was to choose a methodology. Section 3.1 outlines the path I took in trying to find the most appropriate way to come to knowledge that would encompass the whole picture. Following that, in section 3.2 I outline the works of narrative researchers from whom I chose to glean method options. The last methodology section 3.3 has information about the way narrative conveys meaning leading to a presentation of the underlying philosophical position of the thesis.

Chapter 3: Methodology

3.1 Journey to methodology - *finding the words*

Presented here are the changes in my thinking until I found a methodological fit. At the beginning of my candidature as a master's student [Spring 1993], previous to the panel assessment [Spring 1998] that changed this study to doctoral level, I spent two years of chronological time [minus one semester leave for the birth of my first child] investigating the available options and deciding on the type of methodology I would utilise. For this reason the literature presented in this section is less than contemporary and I have not included more contemporary literature to update this section as I wished to maintain the integrity of my research story. I made methodological decisions in relation to the literature that was current at the time and putting up-to-date literature in would be adding after the fact.

I considered several approaches to studying the nursing of patients, whose pain was unknown, before settling on a narrative study. In this section, I will present the philosophical positioning underpinning each of these possible approaches to my research project and I will demonstrate how the pattern of my thinking changed in terms of ontology [the nature of being] and epistemology [the theory of knowledge]. I started with wanting quantifiable measurements of patients' pain. Realising that there was more to nursing unknown pain than a search for elusive physical cues from unresponsive patients, I shifted to desiring an insight into the nurses' experiences of dealing with unknown pain. Even then, I was not satisfied, wanting to deal with more of the complexity inherent in the mix of nurses, doctors, patients, pain and critical illness. I will show the movement of my thoughts from an initial empirical stance [about objective measurement], through to an in-depth consideration of phenomenology within the interpretivist position [about understanding actions and interactions], to taking in ideas from critical approaches [about questioning assumptions], then finally onto the appropriateness of a narrative study [about finding meaning from stories lived and told] for the complexity of nursing.

The methodology, that is the overall guiding strategy of the study, needed to be selected to fit with my implicit or explicit assumptions about the topic and about my perspective on the connection between theory and practice. The way the world is viewed by a researcher influences the choice of research approach (Speedy, 1990)

and inevitably debate continues as to the appropriateness of methodologies and the philosophies on which they are based (Guba & Lincoln, 1989). The methodology of this study is the consistent link between my philosophical stance and the nature of the answers I sought. The presentation of the views and assumptions I brought to the study as researcher that are in section 1.2 will help in understanding the substance and timing of my methodological choices. But first I will delineate my standpoint on the need for philosophical deliberation when deciding on an appropriate research methodology.

3.1.1 About understanding the inclusion of philosophical notions

It may seem that philosophy is a long way from nursing. One may seem to be all about manoeuvring thoughts while the other seems to be all about practical care of peoples' health. However, whether we are aware of the basis of the way we operate in the world or not, there are underlying premises, assumptions and ways of thinking that influence the way we are. Philosophy can be simply understood as purely thinking about thinking and considering our taken-for-granted position on how life works. We take an epistemological position about how we get to '**know**'. Consequently, our beliefs about how we acquire knowledge impacts on how we go about learning, and what importance we place on the different types of knowing. We also take an ontological position about what we '**are**'. Accordingly, our beliefs about who we '**are**' in the world impacts on how much effort we put forward to shape that being or whether we would rather 'go with the flow' of life and take what comes our way.

Even though philosophical positions, in terms of epistemology and ontology, are inherent in the way we live, actually reading philosophy may not be the favourite pastime of many nurses. Philosophical writing may seem to be a foreign language but it is my intent here to make the philosophy that is relevant to this study readable and understandable. It is here that the clinical voice may override the academic voice as I try to convey the thinking underlying this study in a way that is easily accessible to clinical nurses whilst not compromising with integrity.

Because the intent of a thesis is the formation of new knowledge, a necessary element of thesis writing is consistency. All the elements, from locating a particular problem, using a particular way of looking at the world, and executing a fitting method of addressing that problem, to proposing what will be done with that new knowledge, need to sit comfortably together. For each of the research possibilities that I considered, I will detail the corresponding research questions and appropriate

methods. This will enable me to show consistency of beginning presuppositions, philosophical stance, method and desired outcome.

My choice of research methodology was influenced by what explicitly I wanted to find out about nursing pain in unresponsive patients, together with what I was exposed to through my reading of the literature and contact with other researchers. As I worked with each methodological possibility, the specific area of my research interest was honed. I needed to ask myself whether nursing pain in unresponsive patients could be measured, which would have led me to gather numbers (quantitative data) or whether I needed to gather information using words (qualitative data). In order to make sense of these words, would I map concepts, elucidate issues or suggest links? Would I count responses (quantitative analysis), or would I need to use words to analyse the information gathered (qualitative analysis)? I started out true to the ICU tendency of wanting objective, quantifiable information about my topic, as section 3.1.2 outlines.

3.1.2 About starting my thinking within the empirical paradigm

Researchers locating their understanding within an empirical philosophy believe there are objective truths that exist independently of us as observers and these truths can be known through our senses. Intensive care is a place where a great deal of information about patients is measured. We have numbers for recording units of energy, concentrations, pressures and volumes in respiratory, circulatory, neurological and molecular systems. We administer supportive therapies via specific units of energy, concentrations, pressures and volumes. One of the major aspects of our role as ICU nurses is to observe, measure and record, applying our understanding of pathophysiology, pharmacology and treatment modalities to what patient status information that we or others have noted. Because we primarily focus on the physical recovery of patients, relying on trends in numbers (and alarms on machines), our philosophical starting point in ICU tends towards empiricism.

In ICU we usually assume what we can observe and measure is incontestable knowledge and we naturally seek new knowledge through 'proper' evidence based research: such as control trials and multi-centre studies. However, measurement is difficult in some nursing situations. In the case of the impetus for this research, administering a bolus of intravenous narcotic or adjusting a narcotic infusion involved deciding on a concentration and volume over time. This was a measurable therapy. Yet, the state of the patient's pain was unmeasurable. I felt ill at ease when I was required to give a numerical therapy to an unmeasurable patient state. Because I was

powerless to measure pain in those critically ill ICU patients, who were unable to communicate, at the beginning of my research I wanted to ascertain the most accurate assessment techniques that nurses working in the area used to gauge pain in unresponsive patients.

My empirical research question might have read:

What indicators do experienced nurses working in ICU use to assess pain in unconscious patients?

Looking at the nature of the relationship between the knower and the known in empiricism we find that what is known can exist independently of the knower, the only connection being when the knower, through use of senses, observes what is out there (R. Holmes, 1986). Basing our way of dealing with pain on empiricism would mean that patients' experience of pain would be an entity that existed independently of nurses. It would be our job as nurses to observe that pain experience only through the use of our senses and then base our choice of therapy solely on what we observe. In empiricism, the cause and effect link between what is known and the effect of what is known on the knower is unidirectional. The knower is not permitted to contaminate the known and thus cause the known to become suspect (R. Holmes, 1986). To explain this concept, under empiricism, as nurses we know physiological causes of pain and we can respond to what physical pain cues we observe, but we must observe only what is there and not put onto the patient assumptions from within ourselves. As a beginning position I pursued an objective way to measure pain in unresponsive patients, but problems exist when there are minimal cues to observe. We are not privy to a clear picture of unresponsive patients' pain and so within empiricism we must not contaminate our assessment with our independent assumptions.

The intent of research within the empirical paradigm is to find the similarities among people or things in general and thus add to our knowledge of them. The aim is to produce a context free theory that applies universally by undertaking studies that manipulate and measure variables or factors (Allen, Benner, & Diekelmann, 1986). The researcher is expected to approach the investigation objectively, without personal involvement that would bias or confound the result, so that the reality that is believed to exist out there may be found. Empirical research studies use knowledge from previous studies as a foundation on which to base presumptions and predictions. Ideally this base holds a reasonable volume of previous literature. Present theories are tested by confirming or rejecting current knowledge until a natural law becomes evident. This

natural law is then used to explain or predict at times when we cannot be certain. However, in relation to this study, there was a lack of literature on the topic of nursing unresponsive patients' pain and the subjective nature of pain would render the generalisability of findings as invalid.

I gained insight into how objective, specific and measurable an empirical study of nursing pain in unresponsive patients needed to be by reading the empirical research that existed around the topic of pain at the commencement of this study. For example, LeResche and Dworkin (1988) videotaped facial expressions of patients suffering from chronic temporomandibular disorder, who were undergoing a painful clinical examination procedure, and compared the recorded facial expressions with a completed McGill pain questionnaire, Spielberg State Anxiety Scale and Zung Depression Scale for each patient. The facial expression was coded using action units which described the intensity of individual facial muscle movements. An integrated pattern of movement of the facial muscles, which could be labelled a painful facial expression, was found to exist. The frequency of occurrence, duration and intensity of this expression was found to positively correlate with the patients' self-report of pain and the presence of the affective components of pain, anxiety and depression.

At this point in my journey to find a suitable methodology I realised I needed a more explorative approach as there was very little previous research on which to build. I wanted to understand the pain experience of unresponsive patients in order for us, as nurses, to be sure of our assessment of pain. However, in the absence of obtainable data from unresponsive patients, I turned to consider the perspective of nurses. Still located within the empirical paradigm, I investigated the possibility of embarking on a clinical decision making study.

3.1.3 About the idea of mapping nurses making decisions

The belief that nurses undertook a mental process from observing cues of pain through to choice of treatment spurred my original search through the literature for some documentation of this process. When I did not find such an exposition I considered an analysis of nurses' clinical decision making as a way of securing this missing information. Because I was not able to externally measure what was happening for nurses in this situation (quantitative data), I needed to collect words through talking to nurses and thus obtain examples of their thinking (qualitative data) and then by measuring nurses' words (quantitative analysis), create a decision tree or algorithm. Measuring and quantifying good decisions about nursing pain in unresponsive patients

would lead to an explicit decision making process that could be applied across all uncertain situations. If I had undertaken a clinical decision making study then a pain assessment tool to be used in relation to unresponsive patients might have been one major outcome.

3.1.4 About valuing the human complexity around objective measurement

I moved away from using clinical decision making because the match between the sort of diagrammatical representations this methodology produced did not fit together easily with the way I practiced as a nurse, especially when I was uncertain. I felt that the issues involved in this nursing situation, especially the subjectivity of pain would not suit a prescriptive type of structure, such as a decision tree, however complex and elaborate it may be. I believed that each nurse, each patient and each pain experience varied and I wanted to explore the differences as well as the similarities. Information processing and statistical decision theories which produce tools for decision making such as algorithms and decision trees are useful for relatively structured problems. When clinical situations are more complex and are unable to be reduced to a limited set of options, these modes of decision making may not be quite adequate (Patricia Benner & Tanner, 1987). From my own practice and reading of literature, decisions about comfort and pain seemed to involve professional, social, personal, and interpersonal influences that would make diagrammatic representation limited.

Clinical decision making research studies often use vignettes and simulation but I wanted to investigate actual practice rather than possibly artificial, contrived or incomplete scenarios. Some studies concentrated on simulation in order to eliminate situational factors so that observation of variations in nurses due to experience, education and personality could be identified (Patricia Benner, Tanner, & Chelsa, 1996; Fonteyn, 1991; Jenny & Logan, 1992; Christine A. Tanner, Padrick, Westfall, & Putzier, 1987). Removal of nurses from the clinical context by using vignettes which offered selective information did not allow for consideration of normal clinical conditions where nurses interact with patients, see the non-verbal signals which are difficult to describe in a written form, and choose cues to which they will respond (Harrison, 1991). I wanted to obtain information from nurses about their practice within the actual clinical setting so that the nuances could be known as well as the more obvious elements of the situation.

Experts in both medicine and nursing have been found to use a non-linear problem-solving approach (Grobe, Drew, & Fonteyn, 1991; Kassirer & Kopelman, 1986).

Decision theory, which uses mathematical models to prescribe optimal clinical judgment, and information processing theory, which uses verbal processes to describe the judgment process, are both inadequate in those nursing situations where there is not a step-by-step process. Instead, as Fonteyn (1991) suggests, an understanding of clinical judgment would be best found through investigating what expert practitioners do in everyday practice.

Mapping down a nursing decision tree could have alleviated the tension of not knowing and not being able to measure. However, the inherent complexity in pain, comfort, and the critically ill, that I knew from my practice and from the literature led me on to consider other ways of approaching my questions and finding insights that addressed the involvement of our humanness.

3.1.5 About considering human interactions and experience within the interpretivist paradigm

In searching for a methodology that would cater for the multiple levels of complexity that I personally knew surrounded nursing patients in unknown pain, I turned to the interpretivist paradigm. At the time there was an emphasis in the faculty on qualitative methodologies with students mainly undertaking grounded theory or phenomenology projects. Interpretivist methodologies cater for exploring the motives, meanings, actions and reactions of humans within a social world in order to understand and explain complexity (Allen et al., 1986; Guba & Lincoln, 1989; Schultz, 1987; Silverman, 1985; Speedy, 1990). The human experience is foremost in the researcher's focus (Minichiello, Aroni, Timewell, & Alexander, 1990). Researchers within the interpretivist paradigm might say to the empiricists that generalising is not possible because there is no single reality, rather, each individual experiences their own reality. Researchers influence what they are investigating. Working within interpretivist paradigm is to search for understanding by unfolding some aspect of the living, human experience of the participants. Findings do not claim generalisability, however, readers may add the findings to their understanding of the world, often through the 'ah ha' experience. [Refer to Appendix M].

After having read some nursing research using methodologies within the interpretivist paradigm (Buckenham & McGrath, 1983; Lawler, 1991; B. Taylor, 1993, 1995; B. J. Taylor, 1992, 1993; Allan John Walters, 1992; A. John Walters, 1994), I responded with a feeling of consistency between their presentation of nursing and my experience of it at the bedside. I found reading this research interesting. I wanted to do the kind of

research that revealed the nursing that happened in my particular context and bring to light or uncover new things that were outside my realm of thinking. Receiving words from nurses about their role in nursing unresponsive patients' pain situations (qualitative data) would lead to analysis through looking at meanings and issues (qualitative analysis).

I followed leads into three of the methodologies within the interpretist paradigm; grounded theory, phenomenology and narrative analysis. These were examined consecutively, and I only moved onto the next when I eliminated the one I was considering. Questions I weighed up included: whether I wanted to elucidate a core social process?, or whether finding the lived experience of nurses was what I needed?, or whether looking at nurses' stories would reveal what I wanted to know?

3.1.6 About seeking core social processes using grounded theory

Some people say that grounded theory sits on the fence between the empirical and the interpretivist paradigms. The intent of grounded theory is to identify core processes (similarities) functioning within a social situation in order to generate and verify a theory. This theory is then able to be generalised. To be grounded, a theory must:

1. fit (categories and terms of construction account for data and information obtained)
2. work (provides level of understanding that is acceptable and credible to respondents and researcher)
3. have relevance (deals with situational problems and processes)
4. be modifiable (open to continuous change to accommodate new information) (Guba & Lincoln, 1989, p179)

Grounded theory leads the researcher to use to several methods of data collection, including observing, interviewing, reading literature, and self-reflection of one's own experience (Baker, Wuest, & Stern, 1992; Chenitz & Swanson, 1986; Glaser & Strauss, 1967; Patton, 1990; Strauss & Corbin, 1990).

My research question as a grounded theorist could be:

What is the core social process at work when nurses working in ICU assess pain in critically ill patients who cannot communicate?

Grounded theory can be used to find understanding that is socially central to or the social essence of the research topic by identifying core processes functioning within a social situation and then generating and verifying a theory based on the processes

found. The approach begins with a clean slate in the researcher's mind.

Presuppositions are put aside. What is hoped will emerge are understandings of processes within individuals or amongst interactions between people that will together form a theory to explain what is going on. Obtaining information may be through interviewing, where the researcher pursues issues raised by previous participants in subsequent interviews with other participants, or using observation, reading literature, and self-reflection on one's own experience (Baker et al., 1992; Chenitz & Swanson, 1986; Glaser & Strauss, 1967; Patton, 1990; Strauss & Corbin, 1990).

3.1.7 About wanting width in addition to the depth of grounded theory

Because I was a clinician and my topic sat within my clinical work environment, it would not have been easy for me to come to my investigation putting aside my own thoughts and experiences. Also, my pursuit of width as well as depth of insight led me to question the interview method of following leads. I felt that if I brought to the current interview issues raised by previous participants I might be either diverting or focussing the current participant and thereby stifling what might otherwise have been offered. I gained insights from other nurses who used the grounded theory approach (Baker et al., 1992; Jones, 1994; Lackey, 1992; Mills, 1989) which led me to conclude that had I used this methodology I would have found the social core of what was happening for nurses at the bedside considering the pain of a unresponsive critically ill patient, but I wanted more.

3.1.8 About understanding individual experience through phenomenology

When I began the process of learning about the philosophy and methods around phenomenology, my main source of information was nursing literature. I did not fully delve into the philosophical writings by phenomenologists. My understanding did not develop fully as I subsequently moved away from phenomenology, but many concepts from my phenomenological reading remain in me and are part of this thesis. Presented here is the extent of my knowledge of phenomenology at that time early in my candidature when I seriously considered the Van Manen approach as being the most appropriate methodology for my study. I have also presented my understanding of some philosophical concepts associated with phenomenology such as hermeneutics, interpretation and meaning in language. Here is my early learning in phenomenological thought and the select philosophical underpinnings that had an impact on my thinking later in my research.

The intent of phenomenology is to find the essence and meaning of an experience. The English word 'phenomena' is derived from two Greek words which translate "to appear" and "to say", therefore the phenomenon shows itself and is made known through language (McPherson, 1987). Phenomena can be defined as an area of interest for philosophical inquiry or the subjective experiences of individuals (B. Taylor, 1993). Phenomenology allows researchers to interpret lived experience as a totality (B. J. Taylor, 1993).

My research question as a phenomenologist could be:

What is the essence of the experience of the ICU nurse in managing pain for critically ill patients who cannot communicate their pain?

According to the philosophy of Gadamer (1975), when we interpret the meaning of something we are in fact interpreting an interpretation. Within the various forms of phenomenological research I mainly read about descriptive and hermeneutic methodologies. In descriptive phenomenology interpretation can mean 'pointing to' something, whereas in hermeneutic phenomenology interpretation is 'pointing out' the meaning of something (Minichiello et al., 1990). Meaning is not solely the property of either the individual or the situation but is a transaction between the two. The unit of analysis is the transaction rather than the individual. The underlying notion is that the individual constitutes and is constituted by the situation. It is then understood that meaning is shared and handed down culturally through language, skills and practice (Allen et al., 1986; Patricia Benner, 1985).

Phenomenological research emphasises the meaning of lived experience. There is no mind/body distinction as with Cartesian subjects; to be a person is to 'Be-In-The-World' (Allen et al., 1986). Dreyfus (1986) called this 'embodied intelligence'. Other people's experiences are borrowed in order to understand the significance of an aspect of human experience in the context of the whole human experience (Minichiello et al., 1990). Phenomenology broadly is the study of the uniqueness of each human being (Minichiello et al., 1990).

Both nursing and phenomenology share beliefs and values that people are whole and that they can create their own particular meanings. Both view people as subjective beings whose objective and subjective experiences are meaningful in terms of the context they find themselves in. Nursing is a humanistic activity which focuses on people interacting. In nursing, '**Being**' is the nurse-patient relationship as it is lived in a

particular health context. Attending to the intentions and meanings of nurses would be a worthwhile way to explore and understand how nursing involves human actions and interactions with human consequences (B. Taylor, 1993; B. J. Taylor, 1993).

Hermeneutics comes from a Greek word which means to explain, in the sense of clarifying the obscure and unclear. Hermeneutic phenomenology studies human pragmatic activity, everyday understanding and practices, and relational issues which is distinctly different from the study of objects (Patricia Benner, 1985; B. J. Taylor, 1993). Hermeneutic phenomenology is concerned with human behaviour as it occurs and unfolds in everyday situations (McPherson, 1987).

Hermeneutic phenomenology has three essential notions:

1. Humans are self-interpreting and these interpretations constitute self.
2. A person takes a stand on their “Being-In-The-World”.
3. Meanings are limited by language, culture and history.

(Patricia Benner, 1985)

Hermeneutics assumes that researchers have pre-understanding on the basis of shared culture and that is how researchers arrive at their research question.

Hermeneutics also assumes that there is no Archimedean point from which the researcher has a universal view of the world but rather researchers share the world with the subjects (humans cannot stand outside history in order to have objective interpretation) (Leonard, 1989).

3.1.9 About the method of phenomenological research

Phenomenological research interprets everyday practical activity to discover hidden meanings. The meanings are hidden because it is so pervasive and taken for granted that it goes unnoticed (Leonard, 1989). The goal is to find exemplars [representative examples] or paradigm cases that embody the meanings of everyday cases. This can be obtained through participant observation, field notes or journal, interviews, unobtrusive samples of behaviour and/or interaction in natural setting (Patricia Benner, 1985).

Gathering information for phenomenological studies often involves eliciting other people’s experiences through non-structured or semi-structured interviews (Baker et al., 1992). Van Manen (1990) also adheres to this approach adding that lived experience material can be gathered in conversational interviews and then reflected on in a following hermeneutic interview where each participant becomes a collaborator of

the research project. Other ways of hermeneutic phenomenological reflection include theme analysis, collaborative analysis in a research group, and using the four existentials. These four existentials; space, body, time and human relations can be used as categories for questioning, reflecting and writing (Minichiello et al., 1990).

Phenomenology attempts to look at the phenomena with wide open eyes, with an awareness of preconceived notions, and then requires an intensity of reflection. As a result, interview questions are broad, open ended and designed to avoid influencing respondents' answers in any way (Baker et al., 1992). Meanings can then be uncovered but not distorted, destroyed, decontextualised, trivialised or sentimentalised (Patricia Benner, 1985).

Minichiello, Aroni et al (1990) suggest that in order to obtain a description of lived experience, a researcher needs to avoid causal explanations, generalisations and abstract interpretations, describe experience from inside (feelings, moods, emotions), describe specific events, adventures, happenings and particular experiences, focus on a vivid example (like the first time), and finally, attend to the senses(how the body looks, feels, smells, sounds and tastes).

In hermeneutics there is a systematic approach to interpreting text, involving analysis of the whole text, analysis of parts of the text, and then a comparison of interpretation for conflicts and for understanding of whole in relation to parts and parts in relation to whole. Paradigm cases, exemplars and thematic analysis are useful for allowing particular claims of the text to stand out and for presenting configurational and transactional relationships (Patricia Benner, 1985). One similarity with empirical research could be the consideration of frequencies when looking at text, however, the difference lies in the level and kind of description and explanation. In phenomenology both description and explanation are constituted by meaning (Allen et al., 1986). Collaborative analysis occurs when a group of people review the findings in order to formulate underlying themes and meanings. This allows the researcher to see the limits of their present vision and transcend these limits (Minichiello et al., 1990).

3.1.10 About credibility and trustworthiness

In order for research to add to the current body of knowledge, there needs to be an acceptable standard of rigour. Guba (1981) and Sandelowski (1986) suggest the following four major concerns presented in Table 3.1.1 relating to the trustworthiness of interpretative research and how researchers might address such concerns.

Table 3.1.1 Addressing trustworthiness in interpretive research

Truth value	Credibility of findings and interpretations are tested with the respondents and experts sharing the same life-world.
Applicability	Thick description allows the reader to compare their contexts with that of the research study. This enables the possibility of some transferability between contexts through identification of essential similarities. Generalisations cannot be made that will hold at all times in all places.
Consistency	Variance needs to be traced and ascribed to sources. Audit trails need to be clear.
Neutrality	– the burden of neutrality shifts from investigator to confirmable data.

Sandelowski (1986) then suggests the strategies listed in Table 3.1.2 for interpretivist researchers to put in place to ensure trustworthiness of their project. In particular, auditability would be achieved when the researcher leaves a clear decision trail from the beginning of the research to the end.

Table 3.1.2 Strategies to ensure trustworthiness

<p>How the researcher became interested in the topic</p> <p>How the researcher views the topic studied</p> <p>The purpose of the study</p> <p>How information came to be included in the study</p> <p>The impact participants/information/researchers had on each other</p> <p>How the information was collected</p> <p>How long information collection lasted</p> <p>The setting</p> <p>How the information was handled for analysis, interpretation, presentation</p> <p>How the information was weighted</p> <p>The inclusiveness or exclusiveness of categories of information</p> <p>Techniques to determine truth value and applicability of information</p>
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The soundness of research credibility in phenomenology depends on the extent to which the findings truly reflect the essence of a phenomenon as experienced by the participants. Validity is threatened by the ambiguity inherent in language. This can be addressed by having the interview transcribed and interpreted, then shown to the participants to see whether the findings reflect their perceptions of the experience (Baker et al., 1992; Leonard, 1989). Participants validate the findings when they recognise the interpretation. Additionally, or alternatively, experts can be used to validate the findings as cultural meanings are shared. Using experts with shared cultural understandings is consistent with the view that meaning and order of culture precedes meanings of individuals (Patricia Benner, 1985).

Phenomenological research produces action sensitive knowledge which can be written and presented as text, but ultimately lives in the human being who dialogues with the text. The reader enters the validation process of the text when there is an increase in

understanding of the lives of the participants, themes are found to maintain integrity of information received from participants, interpretations are internally consistent, examples from text that support findings are presented, and the conclusions are consistent with readers' own experiences (Minichiello et al., 1990).

3.1.11 About holding onto complexity in a debate on essence

Phenomenology was conceived by the philosopher Edmund Husserl whose interest was investigating subjective consciousness. Husserl's position involved bracketing or suspending belief in our knowledge and pre-understanding of the phenomena and capturing the essential features through imagination, insight, intuition, explanation and description. Husserl's concepts are presented in Table 3.1.3.

Table 3.1.3 Husserl's phenomenological concepts

Intention	A consciousness of the description of the phenomenon
Description	Of phenomenon as experienced by the individual
Reduction	Preconceptions about phenomenon are bracketed by being identified and put aside, then characteristic attributes are identified through varying the phenomenon imaginatively
Essence	Essential structure (for example, a triangle can be any colour but must have three sides)

Adapted from (Baker et al., 1992; McPherson, 1987)

At the time that I was gaining understanding into the methodology of phenomenology, the bulk of nursing phenomenological studies fell under the philosophy of Martin Heidegger, a student of Husserl. The distinction between Husserl and Heidegger was the approach researchers need to take towards the background pre-understanding. Husserl believed that any pre-understanding needs to be put aside, whereas, Heidegger believed that, if we are to understand the meaning of things, what we know and understand, in addition to what we see, must be taken into account. Although we may not be able to fully make explicit nor be completely clear about this pre-understanding, it is what makes human beings different to artificial intelligence. We come with a story that contains the conditions for actions and perceptions. This background is not individually derived but is handed down (Patricia Benner, 1985). Heidegger suggests that a person is a self-interpreting being who comes to be defined by living a life. People understand their world in terms of the meanings within them (B. J. Taylor, 1993).

Heidegger's phenomenological approach fits together with Hans-George Gadamer's hermeneutic approach. According to Heidegger and Gadamer, experience is not longevity or mere passage of time, but turning around, or refining of preconceptions. Experience is already interpreted. This understanding of experience aligns with the concept that a person never approaches a situation without a pre-understanding. Experience comes about as a result of a discrepancy or a disruption that causes one to reflect on a particular activity and come to terms with why expectations are not met by that activity, performance or situation. Each experiential encounter then is one step towards fluid, non-problematic skilled performance (Allen et al., 1986).

Phenomenology acknowledges and values our life-world, then attempts to explicate the meanings that we give to our own experiences in everyday existence. The human world comprises mind, thoughts, consciousness, values, feelings, emotions, actions, and purposes; these manifest in language, beliefs, arts and institutions. Our life-world is preverbal and therefore hard to describe. It is therefore a challenge for phenomenology to attempt to do the impossible in constructing a full interpretive description of some aspect of the life-world. Yet phenomenology is aware that the lived life is much more complex than any explication of meaning can reveal (Minichiello et al., 1990).

Reading a variety of phenomenological nursing research studies (Allen et al., 1986; Baker et al., 1992; Bartky, 1990; Patricia Benner, 1985; Crotty, 1994; Drew, 1986; Dzurec, 1989; Forrest, 1989; C. Holmes, 1992; Lackey, 1992; Leonard, 1989; McPherson, 1987; Rather, 1992; Ray, 1985; Steiner, 1978; C. A. Tanner, Benner, Chelsa, & Gordon, 1993; B. Taylor, 1993; B. J. Taylor, 1993; Van Manen, 1990; Allan John Walters, 1992) helped me to understand the possible endpoints for my study. These studies described the 'lived experience' of nurses within varying contexts. Meaning was sought through attempting to establish the essence of the situation, or what nurses do in particular situations, or what the essence is of nursing. Phenomenology was an attractive methodological option because I thought I would be able to get to all that was happening for nurses in this situation. I did not want to miss information which may have been possible through following leads in a grounded theory style research study. I believed that phenomenology was less likely to place limits on the words gathered.

Closest to my area of interest was the work of Walters (1992; 1994; 1995) who used a Heideggerian phenomenological approach to research the experience of being an

expert ICU nurse. Walters' assumption in his approach was that understanding would be intricately involved with a person in their world. There is no separating subject and object. Essentially this approach asks what the experience is like (Van Manen, 1990). So to define the nursing experience of managing comfort and pain in unresponsive ICU patients, using Heideggerian phenomenology I would find out what it was like for nurses to 'be' there.

My research question as a Heideggerian phenomenologist could be:

What is it like for ICU nurses to care for a critically ill, adult patient who is incapable of purposive actions, with regard to comfort/pain? What do these nurses see, think, feel, do, and what helps or hinders these nurses to achieve the goal of a comfortable patient?

I actually started down this road as a viable option until I went to Michael Crotty's workshop on phenomenology and was presented with the Heidegger versus Husserl dilemma (Crotty, 1994). Crotty claimed that the Heideggerian phenomenology that many nurses were using in their research at that time was not in fact pure phenomenology. Crotty espoused instead the Husserlian approach to phenomenology. Husserl separated subject and object, recommending a researcher bracket their presuppositions about a phenomenon before an investigation so that they would be open to finding the essence of the phenomenon itself. What happened at this point in time of my research journey was that I was quite happily going to adopt the phenomenology 'lived experience' version when I became disillusioned by the information presented at Crotty's workshop. After this workshop I had trouble on two counts; firstly, I was not established enough in the Heideggerian approach to stand firm and continue, preferring instead to not be involved in an approach that was possibly controversial, and secondly, I couldn't work out a way of using the phenomenology Crotty talked about to get at what I wanted because I was not looking for the essence of a phenomena. I didn't want to find out "what is pain?" nor "what is nursing?".

I moved from a phenomenological approach for my research as a direct result of my disillusion over the debate in nursing between Husserl and Heidegger's approaches and also coincidentally, my simultaneous attraction to the stories or anecdotes in the phenomenological works that I had read.

3.1.12 About explanatory and expressive forms of knowledge

I became drawn to the power of exemplars and stories found within phenomenological writing. These stories spoke to me in a deeper way that other research findings did not and I began to notice how often stories were used to communicate thoughts, ideas, and meanings in general conversation. Later, I came to appreciate the difference between expression and explanation as complimentary ways to come to new understandings (Reason & Hawkins, 1988). Benner, Tanner & Chelsa, (1996) claim that stories engage the listener with their own historical understanding and personal knowledge. My attraction to stories led me to investigate narrative analysis as a way of doing my research. Connelly and Clandinin (1990, p2) claim "...people by nature lead storied lives and tell stories of those lives, whereas narrative researchers describe such lives, collect and tell stories of them, and write narratives of experience."

David Carr's (1991) comparison of phenomenology with narrative analysis helped me to decide on narrative analysis as the methodology for my research. Carr maintains phenomenologists are tied to individual experience whereas narrative analysis widens the field of investigation to include the social dimensions of experience by looking at the relationships between and points of view of the characters of the story, story teller and audience. Within this concept, the idea that narrative gives opportunity to hear voices that have not previously been heard, or to find meaning in everyday experiences that are often ignored in the collection of other types of data (Langellier, 1989), resonated with our sometimes devalued status as nurses at the bedside. Given the place we have advocating for these vulnerable patients, I wanted to hear our story as nurses and thus reveal the inner nurse and the outer nurse relating to others and the environment.

My research question as a narrative analyst could be:

What can be known about nursing unresponsive patients' pain through listening to nurses' stories?

Usually, a thesis proposes to explain a phenomenon in order to form new knowledge. Yet, the ambiguity of nursing unresponsive patients' pain lent weight to the idea that expression in the form of stories might shed light on what was happening for nurses. In my study, even the language around explaining pain care was difficult. There was little in the literature, no one word was available to describe patients who were unable to communicate intentionally, the patients themselves were unable to articulate their

experience, and the nurses tended to express in story form rather than hold clear explanations of their practice.

Reason and Hawkins (1988) were educationalists who presented paths of explanation or expression as two different ways researchers could follow to elucidate experience and reach new knowledge. Similar notions have been put forward in terms of denotative and connotative thinking, or deductive and inductive reasoning. In Reason and Hawkins' work, the path of explanation uses classification, conceptualisation and theory-building to analyse whereas the path of expression is involved, lively and animated and allows "meaning to become manifest" (p 80). Expression can take different forms such as words (leading to poetry or stories), actions (leading to gesture, mime or drama), colour or shape (leading to works of art or sculpture), or silence (leading to meditation). Because words in the form of stories seemed most aligned with how nurses normally function, I thought that following the path of expression through storytelling would reveal what happened around nursing unresponsive patient's pain.

Figure 3.1.1 shows the contrasting paths of explanation and expression that might be followed. The diagram does not cover the full range of expression, only word forms. Reason and Hawkins (1988) suggest that the two paths in fact complement each other. It would be expedient to use both paths in a research study. In actual fact, there is a need for a research project to live in the middle between the two paths to gain a complex understanding. As the diagram shows, the path of explanation brings clarity to experience whereas the path of expression illuminates. The French philosopher Paul Ricoeur (1966) substantiates the notion of complementary ways of knowing when he puts forward the 'two requirements of philosophical thought – clarity and depth, a sense for distinctions and a sense for covert bonds - must constantly confront each other' (P Ricoeur, 1966, p15). "A clarity without depth is empty so far as it is capable of shedding any ultimate light upon the mystery of human existence; but a suggestion of depth without rational clarity is merely 'effuse romanticism.'"(Ihde, 1980, p12)

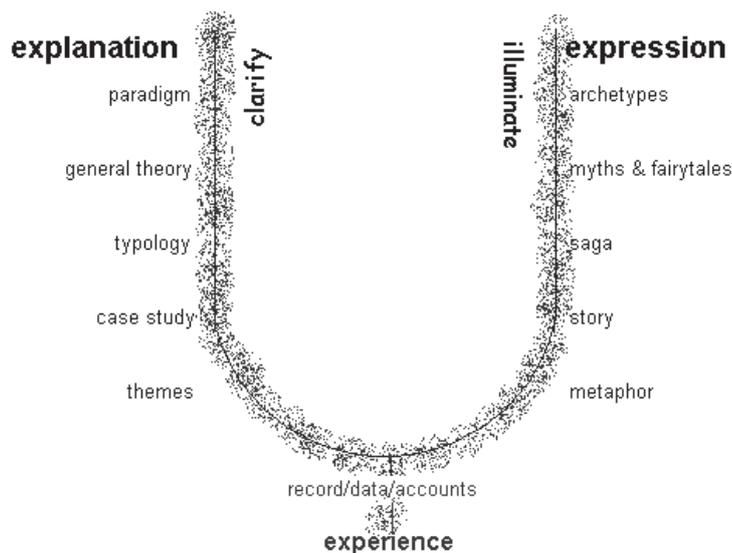


Figure 3.1.1 Paths of explanation and expression
(adapted from diagram by Reason & Hawkins, 1988, p84)

The answer to any question may be in the form of explanation, using objective logic, building on steps towards complexity, using supporting arguments. Alternatively, the response might include a story or metaphor to make the answer clearer. We often use both explanation and expression in conversation when we make a point and highlight it with an anecdote. In my study, because there was no language from the patients, there was difficulty travelling the path of explanation, and so moving up the path of expression filled the void. So my thesis sits in the middle area of the Reason and Hawkins diagram, using elements of expression and explanation to show the complexity of this nursing situation.

It is interesting to note that Reason and Hawkins (1988) have based the progression in the path of expression in the form of words from metaphor to archetypes on work by Maria-Louise von Franz (1982). The progression that von Franz details involves personal stories develop into sagas by becoming part of the local collective folklore. Sagas becoming fairytales or myths when the original content is less important than archetypal patterns and relationships. However, insights can come to individuals from the archetypal level. The explanatory pathway in the form of case studies, typology and general theory are located more extensively in the nursing literature.

Even though storytelling is located on the path of expression in the above diagram, a closer look at narrative analysis as a methodology reveals an explanatory side to stories. Narrative uses a different logic to science in that the explanation and prediction

cycle is broken, instead, it clarifies the significance of events on the basis of the outcome following those events (Polkinghorne, 1988). Narrative looks for connections between events, within context. However, if we examine events backward and forward temporally, they may appear deterministically related. Connelly and Clandinin (1990) caution against the illusion of causality and go on to suggest narrative explanation derives from the whole. In narrative inquiry, the researcher presents evidence to support conclusions and shows why alternative conclusions are not as likely, leaving an open-ended conclusion. New information may show that the conclusion is in error or another conclusion more likely (Polkinghorne, 1988). This is congruent with the emergent nature of narrative and encourages dialogue among researchers and practitioners.

Refer to Appendix L for a tabular form of comparison between the cognitive modes of narrative and logico-scientific thought.

3.1.13 About the way narrative addresses complexity

In making sure of my security in narrative analysis as chosen methodology, I wrote the following comparison, in Table 3.1.4 and then expanding on each point of difference to show the advantage I perceived in pursuing narrative analysis as methodology for my research in Table 3.1.5.

Table 3.1.4 Comparison between phenomenology and narrative analysis

Phenomenology	Narrative analysis
Describes	Describes and explains
Meaning	Meaning
Wholeness of individual experience	Wholeness of situation including individual, context, relationships
Temporality linked to intentionality and being present – a subjective stance	Past influences present story, present looks forward to future, story is frozen in time
Quality and experience of relationships	Relationships between characters in story, between teller and audience, between story and storyteller, power and status

Based on (Van Manen, 1990)

Table 3.1.5 Advantages of Narrative analysis as methodology

Co-participation	I am able to be involved in the formation of the information as a co-participant in the recorded conversational interview
Completeness	I am interested in a more complete picture from the nurse's point of view - action, context, relationships, time - this is the content of stories
Availability	Stories are understandable and available as forms of communication because of their long time and wide use - especially in nursing
Meaning	Stories are told to make a point; the point of the story communicates meaning - I can analyse meaning from the nurses through finding the point of their stories and I can communicate meaning from the research by making a point in the story I tell
Relatedness	There are levels of stories - individual stories, cultural stories, collective stories - how these are formed and relate to each other can show identity, power and politics
Dialogue	logic of narrative - explanation based on the whole, emergent, encourages dialogue

3.1.14 About a critical methodological stance

The lower level of power and status still attributed to nurses and the predominance of females in the profession connected me with the notions of oppression and emancipation being presented. Specifically linked to my study were concepts such as the autonomy of nurses in pain treatments and the impediments to doctors hearing the nurses' assessments of pain.

Critical social theory is interested in language, social habits and the meaning of such structures of human activity, with a central aim of lifting constraints and encouraging autonomy and responsibility (Allen et al., 1986). Researchers within a critical framework would say "So what?" because the intent of these paradigms is to evoke change especially by lifting oppression (action and emancipation). People are valued and the relationship between the researcher and the participants is collaborative.

Feminist theory places value on women, their experience, ideas and needs; acknowledges ideological, structural and interpersonal oppression of women; and participates in political action and criticism to lift oppressive constraints on women (Leach, 1992).

Within the topic of pain assessment in critically ill patients that I wanted to investigate, I considered an explanation of relationships would reveal concepts such as the nurse being a patient advocate (Gadow, 1980, 1989). Considering the vulnerability of patients to under treatment or low prioritising of pain, nurses are in a position to put forward

what they think is an accurate assessment of patients' pain. However, nurses may still be subject to the professional/political hierarchy within the hospital where the doctor has the last say and the patient has no say and therefore tend not to be heard.

My research question in a critical context might be:

What are the social/political constraints on nurses when attempting to assess pain in critically ill patients?

3.1.15 About the universal nature of storytelling

Finally, after much deliberation and soul searching I had arrived at the methodology of narrative analysis. I was satisfied that narrative research comfortably suited my perspective on the way nurses practiced, particularly the complexity of real people in real situations. This personal fit between methodology and my clinical nursing was enhanced by my coming to know the universal nature of storying throughout all peoples and especially within nursing;

...narrative is present in every age, in every place, in every society; it begins with the very history of [hu]mankind and there nowhere is nor has been a people without narrative (Barthes, 1977, p79).

People often communicate their experiences through telling stories. Narrative has been described as "...the prototypical discourse unit" (Linde, 1986, p184), being one of the first types of discourse to be used by children, from the time they learn to communicate verbally. Narrative is used by all types of people in many social situations throughout life to speak about the meanings of both everyday and noteworthy experiences (Langellier, 1989; Linde, 1986; Mumby, 1987). Gee (1989c, p92), claims, "All human beings are masters of making sense of experience and the world through narrative...We are all given this gift by virtue of our humanness, though in some of us it may be atrophying under an avalanche of rational nonsense."

Our lives and the stories we tell are inextricably linked. People encounter life through events, both as participants and observers. Telling stories either from the viewpoint of a player in the action or as one watching enables meaning to be discovered through the elaboration of story telling (Banks, 1992; Polkinghorne, 1988). However, conceptually, there seem to be opposing views on the way we link to stories. On one hand, stories come out from us (constitute); "Stories are lived before they are told." (MacIntyre, 1981, p197). Aristotle identified narrative as imitation (mimesis) or representation of human action (Polkinghorne, 1988). Connelly and Clandinin (1990) claim that narrative focuses on human experience, is a fundamental structure of human experience, and has a holistic quality. Going further along this thought is the idea that narrative dresses

up reality, satisfying our need for coherence, letting us escape from reality (wishful thinking) (Carr, 1991). Hardy (1968) also claims "...narrative, like lyric or dance, is not to be regarded as an aesthetic invention used by artists to control, manipulate, and order experience, but as a primary act of mind transferred to art from life..." (p5).

On the other hand, stories are something we live within (constitutive). Human experience has narrative form and everyday life has narrative features. We are caught up in stories (MacIntyre, 1981; Munz, 1977; Schapp, 1976). The positive side of this view is that even if the story has already been written and the parts we play have been played before, we choose the story in which we live our lives, whereas the more sinister side of this view involves stories putting across a moral view of the world with the intention of power and manipulation (Carr, 1991).

However, Paul Ricoeur (1990) believed there was discontinuity between narrative and the 'real world' and therefore declined to translate mimesis to 'representation' or 'imitation'. He accepted the relation between narrative and its world as being complicated and suggested that the narrative structure "... of beginning, middle and end are not taken from experience: They are not traits of real action but effects of poetic ordering." (p39) Polkinghorne (1988) suggests that narrative is "a kind of organisational scheme expressed in story form" (p13), or "a meaning structure that organises events and human actions into a whole" (p18)

Narrative recognises the meaningfulness of individual experiences by noting how they function as parts in a whole. Its particular subject matter is human actions and events that affect human beings, which configures into wholes according to the roles these actions and events play in bringing about a conclusion. Because narrative is particularly sensitive to the temporal dimension of human existence, it pays special attention to the sequence in which actions and events occur. (Polkinghorne, 1988, p36)

We, as humans, often have a tendency to want to make sense of our experiences and explain ourselves so that we are understood properly, and we find it easier to explain through stories. When stories are told, the narrator reflects on experience and gives it meaning within the story (Kemp, 1988; MacIntyre, 1981; P. Ricoeur, 1986; Tappan, 1990). AJ Greimas (1989), in a dialogue with Ricoeur contends that narrative universals are properties of the human mind. Dell Hymes (1964) claims forms of narration of proverbs, riddles and stories are identical across three thousand human communities. People inherently use these narrative structures as they produce the discourse they speak. Stories in ordinary conversation often explain our own or others' behaviour (Polkinghorne, 1988). Narrative explanation answers the question of why something has happened. 'This happened and so that happened' (Forster, 1927; Gee, 1989c; Hymes, 1982; Scholes & Kellogg, 1966; H. White, 1980). Churchill & Churchill

(1992, p74) state that “Narration is the forward movement of description of actions and events that makes possible the backward action of self-understanding.”

We live immersed in narrative, recounting and reassessing the meanings of our past actions, anticipating the outcomes of our future projects, situating ourselves at the intersection of several stories not yet completed. We explain our actions in terms of plots, and often no other form of explanation can produce sensible statements (Polkinghorne, 1988, p160).

3.1.16 About nursing’s love of stories

Narrative accounts of actual clinical examples reveal everyday clinical and caring knowledge central to the practice of nursing. The concerns, fears, hopes, conversations, and issues of nurses are disclosed and preserved in telling and discussing the stories. A story allows for less linearity, more parentheses or asides, and better captures both forward and retrospective thinking, because the end of the story is known by the storyteller. Thus, narrative can better capture practical clinical reasoning as it occurs in transition (Patricia Benner et al., 1996, p xiv).

Nurses in particular have a tradition of relaying knowledge orally. Mainly confined to tearooms, to colleagues at handover and at the bedside, and occasionally to students, we reflect on what we do and how we feel by telling stories; referred to in the literature as 'reflection-on-action' (Judith Lumby, 1991; Parker, 1990). This oral storytelling has been attributed to a need for confidentiality and the inadequacy of available paperwork (Judy Lumby, 1995).

Gee (1989c) explains ways of communication as placed along a continuum from oral to literate strategies with people using ways closer to one end or the other as the task and context demands. Gee also understands that certain groups of people extend further in one direction or the other. Although nursing has an oral story telling tradition, the stories told tend towards Gee’s described literate style (topic centred) rather than his oral style (topic associating). Oral and written narratives are formally distinct, but not culturally distinct in any meaningful way. Orally composed literature is distinguishable from written literature on the basis of its form rather than its content (Scholes & Kellogg, 1966). The problem with even writing in narrative form according to Lumby (1991) is that the richness of the practice is lost in the written word. Our best communication of practice remains in oral storytelling.

Patricia Benner (1991), Benner, Tanner et al. (1996), and Anne Boykin and Savina Schoenhofer (1991) claim narratives show nursing practice preserved in its wholeness, revealing the uniqueness, subtlety and depth of nursing knowledge. Benner (1991) claimed narratives function in everyday nursing to depict situations that show what it is to be a nurse (the worth of work), or display elements of learning. She elucidated themes such as being present, fostering care and connection, and delineated

narratives of learning, such as the skill of involvement, disillusionment, liberation. Benner analysed narratives obtained through nurses' class presentations of paradigm cases (clinical situations that teach the nurse something new about nursing). She showed how narratives are built through concrete first-hand experiences and these narratives, as memories, help the novice move towards skilful practitioner, according to the Dreyfus Model of Skill Acquisition (Patricia Benner, 1984). Nurses carry these stories forward causing them to notice patterns and salient events, through their emotional responses.

Stories can contain tacit knowledge (Vitz, 1990). Many nurses have clinical exemplars that are etched into their memories where the essence of a nursing ethic could be found. We develop in our practice when we listen to what our experiences with patients tells us (Parker, 1990). When we tell narratives of actual practice situations, we share reflection on our practice and communicate visions of excellent practice (Patricia Benner et al., 1996). Rather than being written, the knowledge that expert nurses have about their practice has been handed down mainly by word of mouth (Judith Lumby, 1991) or by role modelling. Nurses' narratives of first hand experience point to relations between nurses, patients, families, other health care workers, showing what is high-quality practice as well as where there are deficits. For example, actual practice is often more complex than ethical theories. Ethical theories may be illuminated by using examples from practice, equally, practice may be clarified by the use of ethical theories. Both processes together can help nurses to learn from professional wisdom as well as successes and failures (Patricia Benner et al., 1996).

The familiarity of storytelling and nurses' oral tradition in handing down salient knowledge, together with the capacity for stories to address complexity, were ideal grounds for using a narrative approach to the topic of nursing unresponsive patients' possible pain.

3.1.17 Summary

Within this section, I have tracked my movement in decisions on how I might go about finding answers to my dilemma of not being certain of my pain care for an unresponsive ICU patient. The questions arising in nursing are complex and not necessarily answered by a particular research methodology (B. Taylor, 1993). There was alignment between my methodological search and how I came to ask the questions in the first place. Being true to my empirical outlook, I started by investigating clinical decision making as a way to document the confident approach evident in my

workplace. I believed nurses who seemed to know what they were doing would be able to provide me with how they assess pain and then show the steps in their clinical judgment. These steps would then become available to teach nurses who were less confident or new to the area. I would be able to produce guidelines and a decision tree. However, I could not reconcile the ordered step by step approach of decision making algorithms with the fluid way my nursing practice happened. The fit wasn't there for me. I had begun to understand about complexity and the many forces impinging on each of the decisions nurses make.

Grappling with complexity moved me into the interpretive framework where I first encountered grounded theory then phenomenology. Reading about these methodologies and reading studies completed under these methodologies brought clarity to the scope of what it was I wanted to know. I knew that I did not want to undertake a methodology that might limit or restrict the information coming to me because I did not know the extent of the available new information. However, I did know that I wanted holistic information that reflected the nursing perspective that covered how we practised in the context of unresponsiveness, considering pain, interacting with other health carers, patients and their families, in the adrenalin rush setting of ICU. I wanted the whole story. It was good timing to come across narrative analysis as an appropriate methodology.

Stories are so accessible because they are used by all people groups and are the first way we learn to communicate as children. Nurses especially have storytelling as an integral part of their culture, notably in tearooms and evident at handover between shifts. So it is a comfortable way of understanding what is being communicated when the information comes in story form. From section 3.1, we now know that being human, and especially being nurses, means that we use stories to explain. Explaining through stories helps us understand. It would follow then that gathering information in the form of stories in research and presenting findings in the form of a story would be an entirely appropriate way to add to our understanding of the topic under scrutiny.

The scope of narrative analysis to look at personal experience as well as social dimensions of a situation, allows for investigation of the idea of social or collective action, experience and history. I wanted to see the whole picture of how nurses dealt with pain in unresponsive patients, I wanted to hear the voices of those unlikely to speak out, I wanted to see where nurses came from to arrive at the point they are now, and I wanted to tell our story, hopefully locating a place where nurses could be heard

for themselves. All this helped determine the appropriateness of narrative analysis as the methodology for this research study.

Moving from empiricism to narrative widened my view of the problem, allowing for an approach that dealt with the complexity of nursing. Section 3.3 in methodology delves deeper into the philosophy underlying narrative, how stories actually convey meaning, and explores more of the assumptions I bring to this study. However, in the next section 3.2 I will first show how other researchers have undergone narrative studies, some of the pearls of wisdom that I have gleaned from each, and how I have used those gleanings in this study.

3.2 Refinement of methodology - *following the narrative*

This section portrays the quest of finding other narrative researchers, reading how they undertook their studies, and understanding the related philosophy. The area of narrative analysis is broad with a range of approaches that spans both the interpretive and critical paradigms. Telling stories is one of the significant ways individuals construct and express meaning. My journey to identifying narrative as the best approach to fit my intentions in exploring the area of nursing unresponsive patients' pain began with the search for an appropriate methodology, as was presented in the previous section. This journey continued within the narrative methodology as I explored the many diverse ways narrative had been applied to research. I persisted on this journey until I had a collection of narrative techniques that I believed would work for this study. This section presents an overview of my reading from the broad range of narrative research styles, then hones in on the thinking of seven approaches by narrative researchers (Labov and Waletzky, Gee, Agar and Hobbs, Richardson, Mishler, Johnson and Mandler, and Reason and Hawkins) whose works had the most influence on this study.

Research in nursing as well as other disciplines, such as education, psychology, literary science, linguistics and anthropology, have used a variety of narrative analysis methods (Mishler, 1986b). This particular exploratory reading took place early in my research [see Appendix B] and I have not approached contemporary diverse narrative studies as it was important to identify those studies on which I actually made my methodological decisions. Reading such variety in approach broadened the possibilities of how I might undertake my research but also overwhelmed me. The rich diversity of the application of the principles of narrative theory created an opportunity

for me to craft an approach that made intrinsic sense in terms of nursing and the particular problem of dealing with pain in unresponsive patients.

The lack of prescription in narrative analysis has allowed researchers freedom to apply the theory of narrative in many ways to find meaning for their studies. I provide just a brief glimpse at the scope of the narrative studies that I examined during development of my methodology to demonstrate the breadth of styles that had been applied to the term ‘narrative analysis’. Table 3.2.1 presents an example of the scope of narrative studies. The elements that I gleaned from such a banquet will be discussed in this section.

Table 3.2.1 Scope of narrative studies

Researchers	Narrative analysis methods
(Chapman, 1988)	Content analysis of talk
(J. Borkan, Shvartzman, Reis, & Morris, 1993; J. M. Borkan, Quirk, & Sullivan, 1991; Gregory & Longman, 1992; Reilly, 1993; Uden, Norberg, Lindseth, & Marhaug, 1992)	Thematic analysis of stories
(Gregory & Longman, 1992)	Structural analysis of stories
(B. J. Good & Good, 1994; I. Robinson, 1990; Soderberg & Norberg, 1993)	Investigation of plots
(Hunt, 1994)	Combining plots, themes and characters
(C. A. Robinson, 1993)	How story contents are constructed to fit with dominant stories
(Stevens, 1993, 1994)	Demarcated stories within other talk by accepted story structures, and then grouped stories on content
(Mishler, 1986b)	Summarised each story to ‘core’ narratives
(Agar & Hobbs, 1982)	Used life story analysis to look at the narrator’s intentions and strategies to produce a coherent story
(Hunt, 1994)	Probed how people use the coexistence of multiple narratives to address multiple issues and hold diverse and sometimes contradictory perspectives
(M.-J. D. V. Good, Munakata, Kobayashi, Mattingly, & Good, 1994).	Investigated how people create a story in a therapeutic encounter; time sequencing, beginnings and endings, and finding meanings in both locating this illness in time and locating this encounter within the illness experience while working towards how the story will turn out
(Norman K. Denzin, 1987; Ferraro & Johnson, 1983; Richardson, 1985; Uden et al., 1992; Williams, 1989).	Created collective stories from individuals surrounded by similar circumstances, in a hope to show similarity of experience

As presented in the previous section, my thinking evolved from conveniently seeing the measurable in the world to seeking understanding and meaning in the unmeasurable, which for me was the nursing of unresponsive patient’s pain. This shift led me to read more widely and I became more inclusive of other world views. Although this section presents a stepwise and chronological drawing on the work of seemingly divergent thinkers in the field of narrative research, the process within me was much more complex. Each new insight produced more questions and then other narrative works presented pertinent answers.

From the diversity, in Table 3.2.2 I will introduce the seven approaches by narrative researchers that were of most influence on the method of this study and how each influenced my work.

Table 3.2.2 Influence of seven approaches by narrative researchers

Labov and Waletzky (1972; 1982; 1977; 1967)	Defined what elements make up a story, found meaning in story structure, especially the evaluative statements.
Gee (1985; 1986; 1989a; 1989b; 1989c; 1989d; 1989e; 1991; 1984; 1983)	Especially with an oral tradition, focussed on the way words are presented verbally, the flow and sound, and found meaning in linguistic strategies, for example, emphasis and repetition.
Agar and Hobbs (1986; 1982; 1983)	Took whole texts as narrative, analysed the content and searched for coherence and meaning of themes found in life stories.
Richardson (1985; 1988; 1990)	Put together a collective story from similarly situated individuals.
Mishler (1986a; 1986b)	Probed the context of research interviews and found the content to be narrative in nature and co-created by participant and researcher.
Johnson and Mandler (1980; 1984)	Investigated the structure of folk tales as an inherently easy way of remembering a story.
Reason and Hawkins (1988)	Found knowledge can be communicated through forms of expression then encouraged further expressive responses to deepen understanding through a dialectic.

I will not present the culmination of the various divergent approaches on my thesis until the next section, where my particular narrative analysis blend is detailed and supported by a dialectic philosophical stance. However, within this section I will show the forming of notions to ensure consistency of narrative thought across my study despite the use of divergent narrative methods.

3.2.1 About defining words used

Because ambiguity surrounded the words used within the narrative analysis literature, I have provided my definitions for each term in Table 3.2.3. These are the meanings either I have attributed to the following words or I have sought other’s definitions to be employed for the purpose of this thesis. Whilst glossaries are usually appendices these definitions are central to understanding the development of thought.

Table 3.2.3 Narrative glossary

ANECDOTE	A story told to entertain the audience or make a point. I have used this term to refer to the short stories nurses used to clarify or illuminate the point they were making.
COLLECTIVE STORY	A combination of the content of personal narratives from similarly situated individuals presented in a story form.
DISCOURSE	A linguistic unit larger than a sentence, include narrative, explanation, description, argument, command/control (Linde, 1986, p184). An integration of sentences that produces a global meaning that is more than that contained in the sentences viewed independently (Polkinghorne, 1988, p31).
DISCURSIVE CLOSURE	Restricts the interpretations and meanings that can be attached to an activity, resulting in distortion, marginalisation, and misrepresentation of particular groups so that certain realities hold sway over other competing realities (Mumby, 1987).
DISCURSIVE FIELDS	Consist of competing ways of giving meaning to the world and of organising social institutions and processes. They offer the individual a range of modes of subjectivity. Within a discursive field, for instance, that of the law or the family, not all discourses will carry the same weight or power (Weedon, 1987, p35). Relate language, social institutions, subjectivity and power (Foucault, 1976).
DOMINANT STORY	The way things are explained that benefits the people who hold the most power in a situation. Other people may have stories that do not fit with this explanation and which threaten the power balance.
EPISTEMOLOGY	What we believe about knowledge; how do we know?
EXEMPLAR	A story told to serve as a model or pattern for imitation or duplication.
EXPLANATORY SYSTEM	This is the system of assumptions about the world which the speaker uses to make events and evaluations coherent. The simplest explanatory system is the system of common sense (termed folk systems by some researchers). However, many speakers use other explanatory systems derived from expert systems. (Linde, 1986, p188).
IDEOLOGY	Idea or belief structure that holds a particular group together Functions of ideology; 1. Representation of sectional interests as universal 2. Denial or transmutation of contradictions (superficially as simple social conflict) 3. Reification (degree to which social relations and meaning formations come to be seen as “the way things are”) 4. Means of control (through active consent rather than passive acceptance of the situation) (Mumby, 1987, p118, 119).

Table 3.2.3 Narrative glossary (continued)

ILLUSTRATION	Those happenings we speak about which are used to explain by example a particular point we are making.
METANARRATIVE	A way of viewing the world in which an individual locates their own beliefs and explains their own happenings. Like ideology or explanatory systems. For example, science or religion.
METHOD	The actual activity of the research; what I did.
METHODOLOGY	The philosophy that is consistent with the way the researcher sees the world and is appropriate to guide the research study.
NARRATIVE	Talk that covers the content of happenings, people, opinions and ideas. Narrative has a story and a story teller/ a teller and a tale. A drama is not a story as there is no story teller (Scholes & Kellogg, 1966).
ONTOLOGY	What it means to exist; what is it like to be.
PLOT	The way the happenings in a story are arranged by the teller so that the audience grasps the point of telling the story.
PERSONAL NARRATIVE	The mundane happenings of an ordinary day and extraordinary events that mark our lives (Mumby, 1987) located somewhere between literary and social discourse, between written and oral modes of communication, between public and private spheres of interaction, between ritual performance and incidental conversation, between fact and fiction (Connelly & Clandinin, 1990). I have used this term to refer to the entire transcript from each nurse.
RESEARCH PARADIGMS	Ways of conducting research consistent with different ways of looking at the world.
RHETORIC	Persuasive use of language intended to influence the thoughts and actions of listeners but which may be insincere or empty.
SPEECH ACTIVITY	A set of social relationships enacted about a set of schemata in relation to some communicative goal (Gumperz, 1982, p166).
STORY	Happenings (actions/events) told in a form recognisable as a story; 1. Ordered temporally (Chatman, 1981; Labov & Waletzky, 1967). 2. With beginning, middle and end (H. White, 1980). 3. A configuration extracted from a succession (Paul Ricoeur, 1981). 4. Usually told to explain things or prove a point or portray a certain point of view (Carr, 1991; Labov, 1972, 1982; Labov & Fanshel, 1977; Labov & Waletzky, 1967; Wilensky, 1983). 5. Told in a particular way to suit a particular audience (Mishler, 1986b). 6. Sequence of events + storyteller + audience (Carr, 1991). 7. Someone telling someone else what happened (B. H. Smith, 1980), usually of a reportable event (Labov, 1982). 8. Like a tapeworm - its beginning and end are arbitrary (Forster, 1927).
TALK	Things people say.
TEXT	Things said that have been transcribed into writing or written words.
TRAIN OF THOUGHT	The flow of the argument or cognitive reasoning between a teller and audience to which anecdotes are applied to illustrate a point.

3.2.2 About selecting from the variety of narrative analysis methods

While exploring options for a way to appropriately deal with the complexity of this study, I noted that in addition to the broad scope in defining stories there was also a wide range of theoretical orientations and methods for analysing stories. Different approaches to narrative analysis tended to emphasise either the textual (internal connection of parts of text through syntax and semantics), ideational (referential meaning), or interpersonal (role of relationship between speakers) functions. Analysis techniques included looking at structure via syntax, meaning via semantics and pragmatics via the interactional context (Mishler, 1986b). These approaches were used individually or in combination.

Studies using a combination of approaches, such as Susan Bell's (1988; 1999) study of the stories of DES daughters, gave me confidence to pursue an eclectic but purposive mix of narrative strategies to find meaning. Bell interviewed women who were exposed in utero to DES (diethylstilbestrol – a synthetic form of oestrogen). These women have a higher risk of reproductive tract cancer, infertility and problem pregnancies. Within a focused interview, Bell encouraged the participants to guide the flow of talk and provide coherence to their stories. Bell looked at the relation among episodes within stories, between stories within one interview and the roles of the two people involved in the interview in the production of the story.

I learnt narrative expediency from narrative researchers who used a combination approach. Expediency in finding the appropriate narrative analysis techniques that would reveal nursing of unresponsive patients' pain. The next few pages contain aims, methods and examples from the seven approaches by narrative researchers who significantly influenced my thinking, and from whom I combined elements of analysis.

3.2.3 About the structural narrative analysis of Labov and Waletzky

From the work of Labov and Waletzky, I understood that stories were a demarcated group of words, told orally, that were structured to tell of action, the context of the action, the purpose behind the action and the outcome of the action. Additionally, there was a point to telling the story that was divulged throughout the telling. Finding the point of telling would shed light on the meaning of the story. I believed nurses would tell such stories of their actions towards unresponsive patients' pain care.

William Labov and Joshua Waletzky (1967) wanted to investigate why black children failed reading in inner New York city schools yet were competent at relating

happenings verbally with their peers. The question to elicit personal narratives was, “Were you ever in a situation where you were in serious danger of being killed, where you said to yourself - this is it?” This question was used “...because the experience and emotions involved here formed an important part of the speaker’s biography, he seems to undergo a partial reliving of the experience and he is no longer free to monitor his own speech as he normally does in face-to-face interviews.” (Labov, 1972, p355). The result was varying oral stories depicting times when the tellers thought they were in danger of death.

Although the participants and the topic of Labov and Waletzky’s study bore no resemblance to mine, I noted their intention to obtain oral personal narratives which I also intended to do. Labov and Waletzky used the structure these narratives formed and then showed the meaning found within the structure by asking the question, “How does the text function?”

Labov and Waletzky (1972; 1967) approached analysis by distinguishing narrative and non-narrative stretches of text, according to temporal ordering, and applying primarily textual analysis. They described the structure and function of a story, suggesting that stories are used to relate events and to make a point. The object of the analysis was to find the theme or point of the story by looking at temporal connections between units of linguistic expression in addition to how the story corresponded to the real world (Labov, 1982; Polkinghorne, 1988). In other words, to both relate formal structures of a story to their purposes within the story and to identify the discourse function of the story, that is to present events from the narrator’s point of view with respect to both temporality and significance of those events (Langellier, 1989).

Labov and Waletzky (1967) answered the question of what constitutes a story by specifying that at least two clauses in temporal sequence (“and then what happened”) compose a minimal narrative, although a complete narrative contains a beginning, middle and end. However, narratives are often more elaborate than this, leading to their description of the structure of a fully developed story as follows:

ABSTRACT - what the story was about

ORIENTATION - time, place, situation, participants (who, when, what, where?)

COMPLICATING ACTION - sequence of events (then what happened?)

EVALUATION - significance of events / attitude of narrator (so what?)

(penetrated narrative throughout, “reveals the attitude of the narrator toward the narrative by emphasising the relative importance of some narrative units as compared

to others” (Labov & Waletzky, 1967, p37), justified the tellability of the story, and presented the narrator in the most favourable light possible. Evaluative statements can be found through analysis of repetition, intensifiers, and symbolic actions)

RESULT - what finally happened

CODA - story was over and returned to present.

Later, Labov (1982) went on to provide an analysis of the social functions of acts and events in the real world as they are expressed in narrative. He found functional meaning from the original narratives by reducing them to moves [physical actions or change of stance toward listener] and requests [verbal expression by teller of expectation of action by listener].

For example, this is an excerpt from a story about something that happened in Buenos Aires when the respondent (Shambough) was in the merchant marines...

Oh I w's settin' at a table drinkin'.
And-uh-this Norwegian sailor come over
an' kep' givin' me a bunch o' junk about I was sittin' with his woman.
An' everybody sittin' at the table with me were my shipmates.
So I jus' turn aroun'
an' shove 'im,
an' told 'im, I said, "Go away,
I don't even wanna fool with ya."
An' next thing I know I'M layin' on the floor, blood all over me,
an' a guy told me, says, "Don't move your head.
Your throat's cut." (p 235)

Labov reduced this to the moves...

1. The Norwegian sailor challenges Shambough's right to sit with his woman.
2. Shambough makes a counter-challenge to the Norwegian sailor's status as a person.
3. Violence results.

From this later work, Labov (1982) added to his definition of story. He now claimed that although story form was one of many linguistic devices for the recapitulation of past experience, stories were usually told of a reportable event. They provide an answer to "so what", provoking responses such as "I see", "Uh-huh", "Naturally" for ordinary understanding, or "Really?", "Is that so?", "No kidding" for ordinary surprise. Reportable events were by definition unusual, therefore there was a tension between credibility and reportability. This tension was resolved by the evaluation or causality in the complicating action.

Patricia Stevens (1993) based her analysis of marginalised women's health care on Labov's descriptive method. Low-income, American women of colour were asked, "What has it been like for you to get health care?" which gave her extensive stories. She identified stories within the text by their temporal ordering then analysed the content. She claimed that the narrative method allowed her to report the diversity of experience with richness and depth. She divided the participants by their type of health care coverage (which determined the availability of services) then looked for themes within each grouping.

Here is an example of a story from Steven's work showing how this African/American mum uses Labov's elements to make her point that health care is 'not right' within the public sector:

You have to wait forever at county emergency, jammed in there with all the other sick people. Every-body is restless, and the atmosphere is tense. It's scary. It's unsanitary. And people behind the desk act like they just don't give a damn. I have waited 6 and 8 hours with my kids. You can be bleeding and in bad pain, but if they think you will live, you wait. One time I saw another black woman die right there in her chair. She bled to death in front of me from a stab wound in the back...Hours and hours you wait on some doctor who's going to talk down to you and make you feel ashamed. That is not right. That is not right. (Stevens, 1993, p51)

Problems that arise with Labov's work include his disregard for the context and audience and his focus solely on the text as written. The stories were obtained within the context of an interview and were told by black urban males to university educated researchers. The interaction within which the stories were situated seemed of little importance other than to limit the amount of monitoring of his own language the participant might do. Labov saw stories as told rather than an interaction, as entities in their own right; they can be separated from surrounding text and from audience. He believed stories were told in a linear fashion; representing reality as opposed to constituting reality. Others have seen stories as much more complicated, embedded in the surrounding discourse and identifying with, not only the story teller, but also the social group (Langellier, 1989).

3.2.4 About the linguistic analysis of Gee

From the work of Gee, I understood that oral stories fell into a line and stanza pattern that would show what the teller intended through use of poetic techniques. I would find the teller's meaning through noticing the importance placed on phrases through emphases, repetition and other linguistic devices. I believed stories of situations of nursing unresponsive patients' pain would fall into this speech pattern. I thought the poetic version of the transcriptions would be easy to analyse visually.

James Gee (1985; 1986; 1989a; 1989b; 1989c; 1989d; 1989e; 1991; 1984; 1983) was interested in children's oral storytelling. His interest was sparked by a black child's failure in 'show and tell' time at school. He determined the reason for the child's failure stemmed from the expectation that 'show and tell' was supposed to prepare children for essay writing, so a literate rather than oral style of speech was required.

Prompted by the disparity between oral and literate styles of speech, Gee sought to gain some understanding from oral cultures, those relatively uninfluenced by written language. Gee investigated oral style of speech, attending to how the story was said. He analysed pitch fluctuations and pauses in order to group clauses. Gee then described a line and stanza pattern that is delineated by the intonation of the speaker. He believed we talk in little spurts which contain single pieces of information (idea units) and are separated by slight pauses or hesitations of varying lengths. Idea units are put together into 'lines'. Structurally, lines are relatively short, starting with "and" or some other conjugation or a verb of saying, have one pitch glide that terminates the line, often terminate with some sort of junctural phenomena (hesitation, syllable final lengthening, or a short pause), tend to be simple clauses and can display syntactic and semantic parallelism with lines adjacent or near to them.

Lines tend to be grouped into stanzas concerned with a single topic and are often four lines long. Gee showed that oral stories can be transcribed into these lines, stanzas and sections, giving them a poetical appearance, especially when there is parallelism with adjacent lines. When oral stories have been transcribed into these lines, stanzas and sections, they display some of the functional properties of poetry, such as repetition, parallelism, sound play, juxtaposition, foregrounding, delaying, showing rather than telling, which are established qualities of spoken language.

Gee (1989a) undertook further study into native versus non-native speakers' everyday, unplanned speech. He found the native speakers of a language do well at the linguistic techniques of grammar, words, perspective taking, and variation to demarcate social identities. Lack of perspective taking and variation to demarcate social identity is obvious in second language acquisition. Gee was able to show that stresses and pauses (*italics if written*), and pitch level (high/mid/low) or pitch movement (fall/rise), help to show the speaker's perspective and social position, contributing to the audience's understanding of the story.

Gee gave an example of how the storyteller is able to demonstrate John’s perspective towards Argentina through the use of stress on one particular word in a phrase (shown in *italics*)

(John is interested in anything about Argentina)
 “In fact, he just read about the latest *rumours* in Argentina”

(John keeps up with all the gossip about Latin America)
 “In fact, he just read about the latest rumours in *Argentina*”

(John keeps himself well informed on the latest news and gossip on the Argentina situation)
 “In fact, he just *read* about the latest rumours in Argentina” (Gee, 1989a, p4)

Another example relies on the movement of the pitch in a single word to demonstrate the speaker’s viewpoint.

In answer to the question “*Where’s the typewriter?*” “*In the cupboard.*”

- cupboard ↘ (fall) = I assume you don’t and have never known
- cupboard ↘ ↗ (fall-rise) = where it always is
- cupboard ↗ (rise) = why don’t you ever remember
- cupboard ↗ ↘ (rise-fall) = I’m surprised as you are, but that’s what Mary says

(Brazil, Coulthard, & Johns, 1980, p57)

Gee presented a reasonably comprehensive list of perspectives that he encountered in his study. Gee categorised these perspectives into topics. This list of perspectives, as depicted in Table 3.2.4, was used to prompt me to be aware of participants’ similar standpoints in my study through attending to the sound of the teller’s oral presentation.

Table 3.2.4 Gee’s perspectives

Knowledge	(a) How sure I am about what I am saying. (b) How much responsibility I take for the truth of what I am saying. (c) How much I want you to believe and/or trust me. (d) If I am being ironic, sarcastic, speaking figuratively.
Common ground	(a) What I take it we share in the way of knowledge and beliefs. (b) What I take to already have been said and meant. (c) What I take to be in the forefront of your (and my) consciousness or attention, what is in the background of consciousness.
Figure-ground	(a) What information I take to be vivid. (b) What I take to be natural. (c) What information my ego and/or empathy (or yours) is involved with.
Social	(a) If what I am saying contrasts with what has gone before. (b) If I agree with what has gone before. (c) If I just want to add something to what has gone before. (d) If what I am saying is equivalent to what has gone before. (e) If I want to start a new topic, reintroduce an old one, or continue with the one on the floor.

Table 3.2.4 Gee's perspectives (continued)

Future	(a) If I expect agreement. (b) If I want confirmation (yes/no). (c) If I am finished with my turn. (d) If I am willing to be interrupted. (e) If I want you to do something or respond in a specific way.
Present	(a) How I take you to be responding. (b) How I take it you and I feel about the interaction. (c) How polite I intend to be. (d) If I want to dominate you, be equal with you, or be subordinate to you. (e) If I take you and me to be mutual members of a group or not. (f) How direct or indirect I intend to be.
Coherence and cohesion	(a) How what I am now saying relates to what I or you just said and what I or you will say next. (b) How what I am saying relates to what I take us to be doing together. (c) How what I am saying relates to my overall plan. (d) What I take to be important, what not, what in between.
Style	(a) How formal or informal I want to be. (b) How formal or informal I expect you to be. (c) What style, register, and dialect I am speaking in, which I expect from you, and what attitude I have toward them. (d) If I can be trusted to obey the rules or not.

(Gee, 1989a, p6)

The linguistics of Gee enabled me to see the rhythm of spoken English in idea units. I saw how intonation defines lines and then sets of lines are about a single minimal topic. When these lines are organised rhythmically and syntactically they hang together in a tight way and define a stanza. Each stanza displays a point of view. I became aware that attending to the sound of the spoken word allowed for insights that might be lost in transcription.

After becoming absorbed for a while in the fresh and exciting approach of linguistics, I realised that my focus was on anecdotes. Other researchers were more inclusive in what constituted narrative text.

3.2.5 About coherence of life stories by Agar and Hobbs

From the work of Agar and Hobbs, I understood that all of the participants' words should be included in analysis, seeing whole conversations as nurses' stories rather than demarcating stories of happenings and treating them separately. Further, I had more of a sense of the implications of coherence and development in stories. When responding to the dilemma of unresponsive patients' pain, the participants would probably link into their previous nursing experience, which may be similar to reflecting on the past in a life story.

Michael Agar and Jerry Hobbs (1986; 1982) were involved in life-history interviewing. Focusing on coherence, they analysed a narrator's intentions and strategies to produce a coherent story. Agar and Hobbs believed everything the respondent said was relevant to or had a place in the story. Interpretation was based on an analysis of content, as expressed through themes and the interrelatedness of themes.

Agar and Hobbs expressed three general types of coherence:

1. global - how a statement is related to speaker's overall intent for the conversation
2. local - relations between statements and parts of text
3. themal - how statements reflect the speaker's assumptions, beliefs and goals

Agar and Hobbs used these three types of coherence to determine how parts of the story fitted together. The example was Jack's life story of how he learnt to become a burglar. Here is the first episode

. . .And one Sunday morning about ohhhh five o'clock in the morning
I sat down in the Grand -
no, no, not in the Grand Central, in the Penn Station,
and while I was sitting there a young cat came up to me,
and he had his *duffel* bag and a suitcase,
and he said, "Look," he said, "maaan," he said, "I've got to make the john.
Will you keep your eye on the - on my stuff for me?"
(Agar & Hobbs, 1982, p12)

Specifically referring to a time theme, Agar and Hobbs determined line one to show the difference between the straight and addict worlds. Agar and Hobbs claimed that Jack specifying an exact time but not an exact day is consistent with his world as a 'junkie' but inconsistent with application of chronological time or calendar in straight life. Insight gained from line one demonstrated coherence within the total story of Jack's world, told in the situation of a straight listening to a story by a 'junkie'.

As Jack's life story unfolded, Agar and Hobbs saw the shift in Jack from not wanting to attract attention towards an increasingly unconcerned attitude towards robbery even to brazen indifference running out of a property through the occupants as they returned home. Jack himself also commented on this theme of attracting attention within the story noting that people are less attentive than he expected.

As I moved my thinking to look at whole transcripts as narrative, I found within the narrative literature other studies using entire interviews as participants' personal narratives but focussing on different areas of analysis. Studies looked at the context,

such as naturally occurring conversation (Beach & Japp, 1981; Jefferson, 1978; Polanyi, 1985), and the social world in which personal narratives are located and with which there is a reciprocal impact (Cairns, 1994; Norman K. Denzin, 1987; Ferraro & Johnson, 1983; Gregory & Longman, 1992; Hall, Stevens, & Meleis, 1992; Lempert, 1994; Reilly, 1993; Richardson, 1985; C. A. Robinson, 1993; Tappan, 1989; Twigg, 1994), as well as the place of power, ideology, knowledge and identity (Bell, 1988; Mishler, 1986b; Mumby, 1987; Riessman, 1989a, 1989b, 1990; Stevens, 1989, 1994).

Further to the inclusion of the whole text as narrative was the concept of combining stories together. Kathleen Cairns(1994) in a study on sexual assault, coercion and harassment, and Catherine Kohler Reissman (1989b) in a study on the life event of infidelity and divorce, both struggled with working with multiple narrative texts. Each researcher sought to find commonalities across story elements and content types to find the important common fragments of experience which could then be evaluated for meaning.

3.2.6 About the collective story of Richardson

From the work of Richardson, I understood that the stories of participants within a group could be combined to make a group story. I acquired ideas of emancipation and giving voice, thinking that nurses may not speak or be heard at times and do not often take a position of power. I also wanted to give a positive outcome of this study back to the group [being ICU nurses] in terms of communicating clinical knowledge and sharing the difficulty of the experience of nursing unresponsive patients' pain.

Laurel Richardson (1985; 1988; 1990), a sociologist, listened to personal stories of single women involved in long term relationships with married men. Working within a liberation narrative, she wanted to give voice to these women who she believed were ignored, stigmatised and muted. Richardson found similar contours of experience within the different stories and used this to create a collective story. She then placed their narratives in social and historical context to discern what in the contemporary world was disempowering them.

Richardson defined a collective story:

A collective story tells the experience of a sociologically constructed category of people in the context of larger socio-cultural and historical forces. The sociological protagonist is a collective. I think of similarly situated individuals who may or may not be aware of their life affinities as coparticipants in a collective story. (Richardson, 1988, p201)

Richardson's desire to create a collective story came through rejecting other styles of writing such as publication of interview transcripts (because Richardson's opinion was that the unanalysed transcript is not worth reading), paraphrasing (because it lacked credibility, it's boring), self-centred reflexive (because people are treated as garnishes, tasty only in relationship to the main course, the researcher's writing), and separate analysis of stories (Richardson felt this would be writing a collection of socio-biographies).

Richardson explained how her intentions towards the text led her to create a collective story:

My final decision was to organise the research as a unified chronological narrative based on the women's narratives. I typified events and sequences of events, illustrating them through multiple voices and direct quotations. I was trying to simultaneously have the women speak of and for themselves, and for me to speak of and for them as a sociological analyst. I was constructing a collective story. (Richardson, 1988, p205)

Richardson claimed the collective story's function was more than individual stories but different to the cultural story. The cultural story is made up of individual personal stories within a community. Cultural stories help to maintain status quo by linking to stories of heroes and villains across generations. Usually cultural stories are told from the perspective of the dominant players, just as Richardson's example was the story of adultery in a patriarchal system. Richardson claimed collective stories are neither cultural nor individual. Collective stories tell experiences of a social group to which the individual belongs. When the collective stories of silenced or marginalised groups of people are told there may be resistance to cultural stories and the voicing of alternate stories. Richardson moved beyond the constrained view of everyday life narratives, in which we talk to each other about mundane happenings, to how individuals are linked to larger social structures. Richardson argued for linking the personal to the public.

Richardson claimed transformative possibilities for the collective story, both on individual and socio-cultural levels. People live by stories. People's lives can be limited if their story does not fit into the cultural story. New narratives offer alternatives to pattern new lives. The collective narrative can raise consciousness, provide social identity, overcome isolation, link individuals and permit the possibility of social action on behalf of the collective.

My intent is to help construct a consciousness of kind in the minds of the protagonists, a concrete recognition of sociological bondedness with others, because such consciousness can break down isolation between people, empower them, and lead to collective action on their behalf. (Richardson, 1988, p201).

Constructing a collective story using nurses' personal narratives would have the possibility of unifying the group and thus supporting collective action. Although group stories are dynamic, the constructed story would need to be recognisable by group members. Richardson spelt out her criteria for good research using this method. "Although the narrative is about a category of people, the individual response to the well-told collective story is, 'That's *my story*. I am not alone.'" (Richardson, 1990, p129) [original emphasis]

Using a collective story approach, Joanne Hall, Patricia Stevens, and Afaf Meleis (1992) looked at the integration of multiple roles within women's daily lives. They interviewed women employed in clerical jobs, asking them about their experiences as workers, mothers and spouses. The whole of the response from each woman was considered her story. Comparison was made between stories and an attempt was made to create a collective story using common themes, conflictual accounts and patterns. One excerpt from a story showed one woman's flow and movement of energy between her roles.

My divorce a year ago caused me to hit rock bottom financially. I was working as a clerk at the hospital, but I realised that my three children and I were going to need more income than that because my ex husband wasn't paying any child support. So I started school to become an RN. Working and going to school keeps me away from my teenagers. I can't have control at home when I'm gone all the time. And its such an unsafe world for kids, with all the drugs and crime in the streets. But the most important thing is that I'm working to end the financial problems so we can enjoy things more. Because of all this I don't have time to attend the mosque any more. I'm a devout Moslem and that is a real loss for me. (Hall et al., 1992, p451)

Anna Soderberg and Astrid Norberg (1993), also used Richardson's collective story method to investigate ethical reasoning in stories from nurses and physicians in Sweden and Norway. During interviews with nurses and physicians, Soderberg and Norberg specifically asked for stories of ethically difficult care situations that participants had experienced. These researchers defined each care situation as a story and looked for themes across stories. Soderberg and Norberg also intended to form a collective story, which they called a frame story. Comparing the nurses' collective story with the physicians' collective story showed opposite themes. Table 3.2.5 provides a summary of Soderberg and Norberg's findings.

Table 3.2.5 Comparison of nurses’ and physicians’ stories of ethical reasoning

Nurses’ Stories	Physicians’ Stories
Retrospectively	Prospectively
Health and daily life	Disease
Experiential knowledge	Scientific knowledge
Closeness to the patient	Distance
Patient autonomy	Paternalism
Quality of life	Preserving life
Pessimism	Optimism
Death with dignity	Survival
Powerlessness	Power
Being together with colleagues	Being isolated as an individual

(Soderberg & Norberg, 1993)

Because I considered ICU nurses to be a group of similarly situated individuals, the possibility of combining stories across the group and thus giving voice to the area of nursing practice that was devoid of information, was fitting. However, apart from my role as researcher, I was also part of the group of ICU nurses. I needed to understand my impact on this study as a clinical nurse.

3.2.7 About the concept of co-creation of narratives by Mishler

From the work of Mishler, I took it to be the case that I impacted the information that came to me from the participants. Participants’ responses to me as researcher depended on what I said to them in the interview and their perspectives on my expectations of ‘correctness’ and ‘completeness’ of answers. Participant responses would be impacted in particular because I was in the group with my participants as colleague nurses in ICU and seen as a pain expert and senior in the hierarchy. Extending the concept of the influence of the interviewer to a co-creation of story in the interview allowed me to consider adding my thought and ideas on nursing unresponsive patients’ pain to those of the nurses to be used together to find meaning.

Elliot Mishler (1986a; 1986b) is a social psychologist who had extensive experience conducting interviews. Mishler’s work located interviewing in a sociocultural context and examined the effects on participants of different types of interviewing practice. The main premise of Mishler’s work was the inaccuracy of the claim that traditional research interviewing gained pure data. Mishler believed that research interviewing is a discourse with the purpose of eliciting understanding in regard to the meaning of participants’ answers.

Mishler claimed that research interviewing has traditionally been seen as a behavioural event, specifically a stimulus/response type verbal interchange. Therefore, standardising the stimulus, via asking questions in the same manner, would traditionally be deemed to evoke a consistently measurable response. Mishler sees a problem in question and answer units being analysed in isolation because he believes, although behaviours can be isolated, conversations cannot be isolated as they occur in context. Mishler considered variations among interviewers and across interviews not as errors but rather data to be analysed. Mishler thought that interviewing that assumes a behavioural approach avoids the interrelated problems of context, discourse and meaning.

...standard practice provides a set of blinkers that excludes this set of problems from the researcher's field of vision. Work is done as if they do not exist, and work goes forward. Unfortunately, wishing does not make it so, and the social reality that remains alive and active outside this restricted field of vision continues to exert its effects. (Mishler, 1986b, p27)

Mishler held the view that interviews are discourses rather than stimulus response units because interviews are speech events, discourse of interview is constructed jointly by interviewer and interviewee, analysis and interpretation is based on discourse theory and meaning is contextual (Mishler, 1986b, preface ix).

New knowledge gained from research interviewing involves contribution from both the participant and the researcher as well as context and preconditions. Interpretations are made from the link between discourse and meaning. Discourse is developed prior to the interview when there are exchanges between researcher and intended participant. The discourse in the interview is shaped by the previous exchanges. The interview content is formed in the setting of a verbal dialogue where the interviewer and participant are present to each other. Through repeated reformulations of questions and responses, the participant and interviewer make an effort to arrive at a shared understanding of meaning in both questions and answers. Interview responses are more than answers to questions. Answers depend on who is asking as well as the wording of the question. Answers also reflect the interviewer's assessment of whether participants have said enough to serve the purpose at hand.

There is a gap between research interviewing and naturally occurring conversation. In life we ask and answer questions all the time, however, in the context of interview there is ambiguity because the two involved in the interview do not share assumptions, common knowledge and contextual understandings and do not have reciprocal aims.

This ambiguity of interview context may raise problems in the analysis and interpretation.

Questioning and answering are ways of speaking that are grounded in and depend on culturally shared and often tacit assumptions about how to express and understand beliefs, experiences, feelings, and intentions (Mishler, 1986b, p7).

Ordinary language competence should be shared by researcher and respondent in order for research to be effective, however, shared understandings and shared culture would result in more effective understanding of responses.

Mishler showed how interviews can be analysed and interpreted as narrative accounts. Mishler's view was that obtaining stories from participants is easy for the interviewer, citing the case of survey interviewers who seek short answers but often receive long storied responses. He claimed that if participants are allowed to respond until they indicate that they have completed their answers, they are likely to relate stories. Questions such as 'what happened?' or 'why did it happen?' illicit narrative explanations.

The joint construction of discourse by interviewer and participant results from more than exchange of words. For example, interviewers' overt participation may be minimal although they are omnipresent as listeners and researchers. Mishler described the role of interviewer as following the general turn taking of conversation but when a story is being told allowing the speaker to 'hold the floor' beyond limits of normal turn. However, there may be struggle for control of the interview resulting in control being given to the interviewee or solidarity between the researcher and participant. Interviewers are the audience to whom the participants present themselves in a particular light for the purpose of self-protection or maintaining status in regard to the interviewer. Mishler relates an example of divorce interviews, when the male researcher interviewed husband there was no mention of dependence on alcohol, but when the female researcher interviewed wife, the wife told the researcher that the husband was an alcoholic. Knowing that another context would have a different dynamic means that including analysis of the interview situation will help in arriving at a fuller interpretation.

Mishler purports that narrative analysis tells us what the story is about, normative structures of social action, the alignment of personal values to cultural values and how the story serves a purpose in the interview context. However, we always make inferences on the basis of partial information. Mishler's work helped me to realise the

ramifications of interviewing in terms of my impact on the process of procuring words about pain care from ICU nurses. It was after reading Mishler's work that I permitted my personal knowledge to be overt in this study, a position that was far removed from the idea of bracketing from Husserl that I had previously found hard to conceive [see section 3.1.11].

I was now interested in producing a collective story from ICU nurses together with my own contribution, as I was also in the group. However, apart from the structural story definition which suited anecdotes from Labov and Waletzky, I was not aware of, nor confident of, a manner of presenting a larger story. The collective story researchers did not delineate a story presentation structure, so I returned to structural narrative research for further insight into a more complex story structure.

3.2.8 About the folktale story structure of Johnson and Mandler

From the work of Johnson and Mandler, I understood that there was a definable yet complex structure of recallable stories. A recallable structure to presenting the complex findings about nursing unresponsive patients' pain seemed suitable within the oral storytelling culture of nursing.

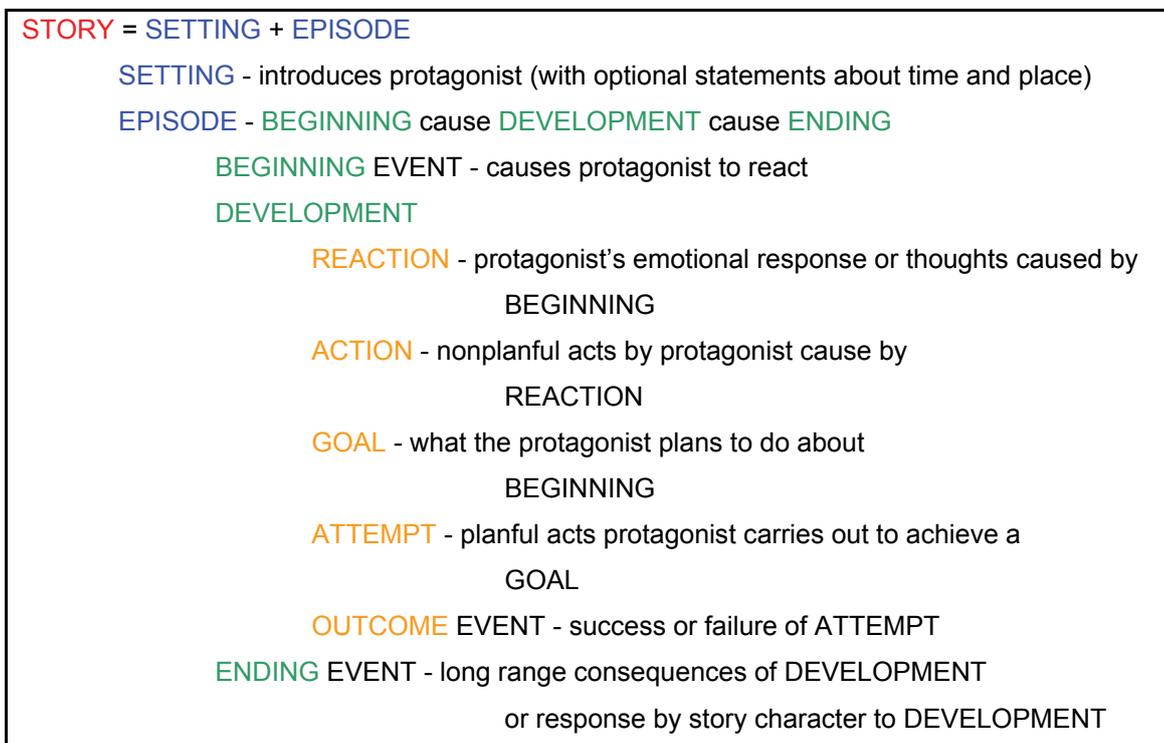
Nancy Johnson and Jean Mandler (1980) are cognitive psychologists interested in the formats or structures of folktales. They assume that when folktales are handed down in an oral tradition, the structure folktale took reflects how the mind organises stories. Because Johnson and Mandler approached this work on story structure from a psychological perspective, they were concerned with the amount of processing required by our minds to come to understand what we hear or read. Through the measurement of comprehension and recall, Johnson and Mandler concluded that a story presented in an expected way is easier to understand. Processing load increases when parts of a story do not fall into the expected order. They explained, "...in our analysis of a wide variety of folktales, we have been concerned with identifying ways in which the structure of stories could enable the inferential and limited processing capacity of the listeners to be maximised." (Johnson & Mandler, 1980, p58).

In a later work, Mandler (1984) believed that people were not necessarily aware of how they mentally process stories. Dependable data would not be attained by asking participants to describe their story schema. Mandler tested the proposed story structure described by Johnson and Mandler (1980). Mandler found recall is greater when participants are told stories with all prescribed components in correct sequence rather

than when missing some constituents, or in a mixed-up order. If some constituents are missing, participants often confabulate them when recalling, preserving the Johnson and Mandler's story structure. When presented with one constituent of the story and asked to generate the rest, participants (even children) follow the Johnson and Mandler's story structure. When given two versions of a story (canonical [one episode followed by another episode] and interleaved [episodes interspersed within each other]), subjects revert to canonical for recall.

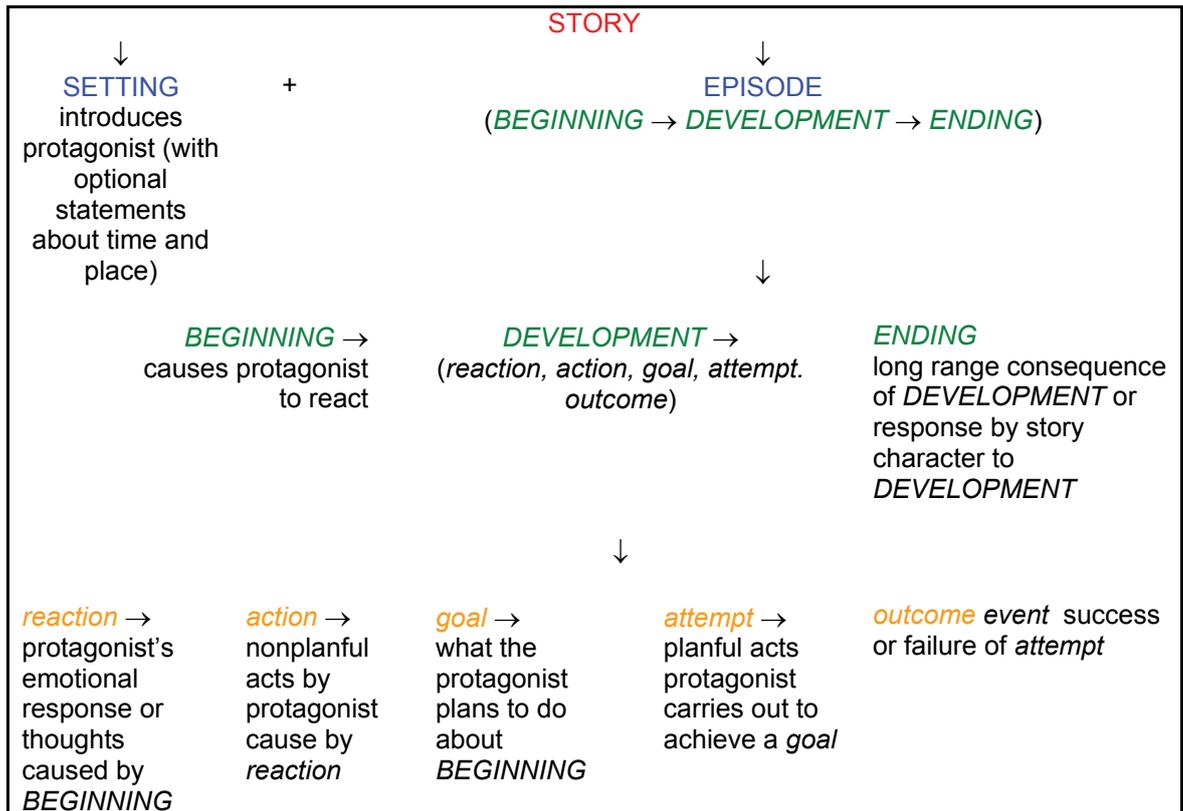
Further, Mandler (1984) measured reading times together with recall for variously structured stories. Mandler made sure that there was accounting for other structures, which might have contributed differing reading times, such as numbers of words, lengths of words, word frequency, new nouns and noun repetition, in order to reduce interference. Mandler found that people can understand stories where constituents are missing or out of position but reading time increased for stories with differing structure. It was also interesting that subjects often recalled stories using the Johnson and Mandler (1980) structure regardless of what order they were presented. Mandler thus claimed the presence of a story schema guides recall and eases comprehension.

The structure Johnson and Mandler (1980) described, found to be present across folktales within different cultures, is depicted in Figure 3.2.1 and Figure 3.2.2.



Adapted from (Johnson & Mandler, 1980, p59-60)

Figure 3.2.1 Simple attempt at visualising folktale story structure



Adapted from (Johnson & Mandler, 1980, p59-60)

Figure 3.2.2 Complex attempt at visualising folktale story structure

Johnson and Mandler's (1980) work was appealing because it was based on folktales; those stories handed down in oral cultures. We as nurses have an oral tradition. Mandler also showed the psychological base of the structure and I thought that the message of my study would be more easily received if it was presented in a comprehensible, recallable way. Additionally, this story structure caters for complexity through multiple episodes, either temporally connected, EPISODE then EPISODE or as a result of an OUTCOME, where the OUTCOME becomes the BEGINNING EVENT of the next episode.

3.2.9 About the expressive responses of Reason and Hawkins

From the work of Reason and Hawkins, I understood that forms of expression may evoke an expressive response, allowing a dialectic between the original and the response or between responses. The meaning held within this process would be multifaceted with depth and would be in contrast to meaning found in interpretation.

Peter Reason and Peter Hawkins (1988) are qualitative researchers who were interested in finding ways of developing co-operative inquiry. In the previous section I presented Reason and Hawkins' concept of explanation and expression as two

complementary research paths from experience to knowledge. Further to the understanding that new knowledge is available within different forms of expression, Reason and Hawkins use group situations to explore dialectic expression. At a workshop, in group work, teachers used storytelling as a way of sharing practice but the anecdotes the teachers told seemed to be more storytelling for storytelling's sake to get deeper meaning. Reason and Hawkins refer to the group's activity as 'wandering around' a story and 'wandering inside' a story (p 87). In the group, someone would tell a story then the other group members would respond with their stories. Reason and Hawkins categorized these responses

1. *reply* - my reaction to your story
2. *echo* - your theme in my story
3. *recreation* - your story re-created by me
4. *reflection* - my story about your story

Reason and Hawkins use responses to 'Don's story' as examples of these categories. Don told the group a story of going to a birthday party as a young boy. He remembered his older brothers being there, the cute birthday girl, party food and games and being accused of kissing the girls. A *reply* came from a group member in the form of a poem:

How can we be with them?
Silly little girls.
What do we say to them?
Silly little girls.
With their bows and their curls.
Silly little girls.
With their ankle socks and their patent black shoes.
Silly little girls.
With their frills and their giggles,
Their cream cakes and fancy jellies –
Silly little girls.
How can we be with them?

And when we do find a way
We're betrayed by our brothers:
'Don's been kissing the girls!'
(Reason & Hawkins, 1988, p91)

An *echo* story came from another group member who shared a memory of buying his childhood sweetheart sweets for her birthday, linking his memory of loving her with finding her sexy, embarrassing his father by publically asking him about the anatomy of sex, experiencing the adult uneasiness because of his indiscretion.

A *re-creation* story turned Don's story into a medieval tale of kings, princes and their quest for the beautiful princess. The youngest prince ended up lost in the wonderful

world of blond curls, cream cakes and golden treasures. This *re-creation* of Don's story employed a form closer to the higher archetype level of story.

A *reflection* story was offered that took a farther off vantage point of an observer of the events of Don's story. The *reflection* storyteller pondered Don's clothing and small size, yet imagined his inner strength in being apart from his parents and confidently interacting in such a social space.

Reason and Hawkins found that in an expressive dialectic, stories quickly move from belonging to the individual to becoming part of a collective. When individual stories are put next to each other there seems to be a collective consciousness in the atmosphere and the shared meaning becomes more profound, especially in the context of strong emotion. Reason and Hawkins give the example of the strong emotional responses to a group member's casual mention of a man's story of visiting Malaysia and Singapore for "a little bit of rape and a little bit of pillage!" (1988, p93) yet when group members responded with forms of expression, the depth of feeling was palpable. A *reply* from a woman in the group:

From the voice of rage
I chickened out
You didn't get the knife in the throat
Your hair ripped off your head
Your prick flung like a limp sausage
To the floor
I didn't even tip you off your chair
Where you sat
Cock sure
Soft irish brogue still liltin'
With your tale of travelling
Your man's story
A so-called hero's journey
Into pus poverty
Here you get your slick badge
Cheap with 'different' women
More easy going
Loosely uninhibited lithesome
Childwhores
Serving, starving, conned and tricked
By tradition
Soft sister
I didn't act
But you may strip the sham
Of European privileged aftershaven
Warriors
And swallowing his raping pillage soul
Along with the spunk

Do not jest thou pallid man
Beware of wounded women
(Reason & Hawkins, 1988, p94)

A *re-creation* story that included the man's trip, the emotional outburst, and the synthesis of a possible better future shows how the expressive dialectic can move beyond discussion or even argument and onto a valuable depth of collective knowledge:

Three men set out on a great adventure through an unknown land. Each day they decided just what they wanted to do, and then they went right ahead and did it. If they disagreed among themselves, they fought, and the strongest got his way. They were like brothers by the end of the journey, with a lusty confidence and love and hate for each other. Behind them they left the shattered ruins of their passage.

Three women watched from a hilltop. They despised those three men and turned their backs on them. Together they tilled the soil, brought forth fruits and flowers in abundance, and shared the wisdom of the years. Long were the silences between them, and their tears and laughter flowed as one. No man wrote their history, for there was nothing to write.

In a world that is yet to be, these men and women meet, and choose each other's company. Together they make love, and children are born to them – yes, boys the sons of women and girls the daughters of men. Sometimes they till the land and share the wisdom, and they journey through fearful and dangerous lands. In each other's eyes they recognize the light of their own, and the recognition is fearful, but they know the answer though they had not known the name of the question. And there is no end to the stories which are told. (Reason & Hawkins, 1988, p95)

The way the group responded to stories with other stories and the dynamic of enhanced collective understanding in Reason and Hawkins' work resonated with my observations of the culture of sharing with each other in nursing. The depth of unspoken understanding and togetherness after a supportive debrief can be unmeasurable. In my research, naturally occurring responses from me as the researcher to the nurses' stories would only add to the understanding this study seeks to reveal. Further thoughts on a dialectic approach will be given in section 3.3.

[Since I, as the thesis writer, am outside the temporal sequence of these pages, I am able to reveal that my expressive responses do form parts of my work.

1. The thesis contains a *reply* story in the form of a metaphor that spontaneously sprang from within me, showing the feelings and ideas the nurses had expressed in their stories
2. The nurses shared *echo* stories when interviewed in response to my story, telling their own stories on my topic
3. I directed effort towards making two *re-creation* responses. The collective story was a combining of nurses' stories in terms of themes in a creative story form. The poem was a reshaping of nurses' metaphors from the interviews.
4. The thesis could be a *reflection* story because it is my journey and what I have found to be important based on what the nurses said.]

From Reason and Hawkins’ work I realised that there are expressive implications for the story told and written and the responses evoked that would impact on the setting of ‘interview’ and ‘research’ versus storytelling as handing on wise counsel in a cultural group.

From other narrative researchers I had an understanding that structure and function of simple stories such as anecdotes contributed to why they were told. I had encountered the meaning of sound in relation to presentation of oral stories. I had expanded my scope of narrative to include the entire content of words I would receive from nurses. I extended further to the concept of group and combination of stories from that group allowing for a critique of the wider culture. I located a psychologically sound way of presenting the complex group story to make it understandable and memorable. Finally, I found room for exchanges in expressive forms as a way of entering a dialectic. The problem I found myself in was the need to provide a way of thinking that would enable consistency between these divergent narrative researchers.

3.2.10 About the narrative thinking of Ricoeur

It was the French philosopher Paul Ricoeur (1979; 1981; 1984; 1986; 1990) whose thoughts on dimensions of text and talk were able to make the seeming disparity amongst my narrative resources come together. Because Ricoeur was connected with Heidegger and Gadamer, in terms of phenomenology and hermeneutics, I had encountered his work during my look into the possibility of phenomenology as methodology. Here I will provide just a short foretaste of the more comprehensive defence of my narrative consistency in section 3.3.

The most salient aspect of Ricoeur’s thinking for my study’s consistency where his dimensions of text outlined in Table 3.2.6.

Table 3.2.6 Ricoeur’s dimensions of text

Formal	System of signs. (linguistic and structural features)	<i>How does the text function?</i>
Historical	Where the text sits in time in tension with where the reader is in their time.	<i>What does the text speak about?</i>
Phenomenological	Text-reader relationship or reading experience. (textual strategies and reader’s mode of reception)	<i>What does the text say to me that is common to the reading experience of others?</i>
Hermeneutical	Tension between autonomy of text and reader’s appropriation. (Gadamer’s ‘fusion of horizons’)	<i>How has my world changed because of reading the text?</i>

Using Ricoeur's concept of dimensions of text allowed me to link together my structural, linguistic, content, meaning, social, political approaches into a method that started on the surface of the text and progressively moved deeper into the text. Ricoeur's hermeneutical dimension allowed my involvement with the text and my contribution as researcher and also as nurse to be manifest in this thesis.

A brief look here at Ricoeur's positioning on narrative provides a way into the wider probe of my underpinning philosophy as presented in the next section. Ricoeur's philosophical position falls equal distance from the critical positions of both Kant's reflective stance and Hegel's speculative stance, accepting some and opposing some of both. In the next section I will show how elements of work from Hegel, Kant, Arendt, and Ricoeur contributed to my understanding of dialectical knowledge formation.

In the debate around how stories and life are linked, in Aristotle's theory of imitation, **mimesis** is directly interpreted as imitation. Ricoeur prefers to define mimesis as an action about action. Ricoeur's mimesis is creative. Ricoeur delineates three steps of mimesis.

Mimesis¹ is the basis of narrative. Human action calls for narration, life stories are to be told, stories happen to us before they are told by us, fictional stories are understandable because they represent what already happens in human action.

Ricoeur's has six notions around human action:

1. actions are carried out to achieve results
2. motives explain actions (why a person did something)
3. people perform or are authors of actions
4. actions are limited by the physical setting
5. actions interact with other people (cooperation/competition/struggle)
6. action brings change in fortune or feeling (Polkinghorne, 1988)

Mimesis¹ is prefiguration, a precondition for textuality.

Mimesis² produces a separate world of action through emplotment. A story is made out of events, to the extent that plot makes events into a story.

The act of the plot is to elicit a pattern from a succession, and it involves a kind of reasoning that tacks back and forth from the events to the plot until a plot forms that both respects the events and encompasses them in a whole. The 'humblest' narrative is always more than a chronological series of events: it is a gathering together of events into a meaningful story. (Polkinghorne, 1988, p143)

Configuration of the narrative involves formal and historical dimensions of text. Here the narrator organises the text using narrative language devices to deliver their message. Semiotics looks at the function of internal parts of the narrative and poetics look at the language for language's sake for insights into codes or messages. Narrators of traditional narratives, such as folktales, may use a combination of the old and the new; sedimentation and invention.

Mimesis³ is when the reader and the text meet. There is refiguration of text by reader engaging with phenomenological and hermeneutical dimensions of text. This is similar to Gadamer's (1975) 'fusion of horizons' where the world of the text intersects with the world of the reader. Ricoeur claims actual action occurs and full meaning happens when the text meets the reader. It is during mimesis³ that there may be a movement from 'distanciation' (out there) where the text stands removed from readers to 'appropriation' (in here) where the text becomes part of the experience of the reader. Ricoeur maintains the closer the text is brought to oneself, the more it is understood.

Presenting the beginning concepts from Ricoeur here regarding narrative allows an appreciation of the extent and depth of thinking around narrative, stories and experience that was necessary. Further thoughts will be added in section 3.3 that will make sure consistency of methodology for this thesis.

3.2.11 Summary

Within this section, I have toured my discovery of other researchers' narrative methods. Each narrative study I read influenced my thinking in terms of the opening or closing of possibilities for the way that this project would be completed. However, some narrative researchers had more impact than others. Labov and Waletzky's work was influential in my understanding of the purpose of the structural parts of stories. Gee's work allowed me to link the oral culture of nursing with the sound of spoken stories. Agar and Hobb's work opened up the whole text as narrative and made content and thematic analysis possible. Richardson's work gave me the scope to pull together individual stories into a combined group story. Mishler's work permitted me to include my contribution to the group story. Johnson and Mandler's work provided a solid format for me to deliver the group story. Reason and Hawkin's work provided me with an opportunity to enter a dialectic of responsive expression. Ricoeur's thoughts on the connection between stories given and stories received granted me the space to include my motley crew of previous researchers' concepts.

From the concepts I have shown from the influence on this research of other works within the field of narrative analysis, the method sections 4.1 and 4.2 will outline the basis of decisions made regarding process and method in this research. But first, the next section 3.3 will go deeper into the philosophy behind my positioning within narrative analysis that is the foundation for this thesis.

3.3 Positioning of methodology - *finding the story*

I will outline finding my way of narrative analysis and the philosophical thoughts supporting my eclectic approach. In my exploration of nursing unresponsive patients' pain, I wanted information that was as complete and extensive as possible. Stories are universally told and comprehended across all cultures, they occur naturally in conversation, and they are a way of communicating that reflects wholeness. We gain insight through stories by the teller revealing their identity, the context, emphasising what is important through linguistics, making evaluative statements, sequencing the plot, revealing their relationship with and intent towards the audience, and revealing characters, setting, and action over time - all with the aim of making a point, that is, imparting their personal knowledge to the listeners. This section moves to the next level of abstraction in dealing with stories as a medium of information in research. I will show how my handling of narrative integrates with what I count as dependable knowledge and what I believe we are, as nurses, either telling or listening to stories - or sometimes 'being told'.

After gleaning the ideas and concepts from other narrative researchers that was presented in the previous section, I will now show that research using narrative analysis is diverse in world views and methods. However confusing an extensive read of narrative research for the purpose of following a method might be, it is also exciting and freeing to awaken to the idea that creativity and uniqueness is possible because of the lack of prescription. Taking what suited the topic of nursing unresponsive patients' pain and my world view, which was introduced previously, I pragmatically formed a narrative analysis method that suited my study. Here is the underlying foundational thinking that supports what may seem to be an eclectic approach to narrative but is in fact carefully considered and expedient in terms of finding out about nursing unresponsive patient's pain.

In a thesis it is simply not enough to choose a way of finding and dealing with new information – a map if you like – researchers are required to support the selected methodology by presenting a consistency in ideas and notions from beginning to end.

For me, there were so many notions around narrative and ways of applying narrative theory to research through which I negotiated, toyed with and then decided on as viable options, until I thought I had settled on a reasonable attempt that sat well with my topic. In order to tie together those different decisions, something deeper and underlying needed to be made plain for all to see. Herein lays my intention to present the way of looking at the world that surrounds my question and method so that the very nature of this route can be seen. This section presents my core narrative concepts and my dialectical philosophical positioning from the critical speculative stance of the German philosopher Georg Wilhelm Friedrich Hegel.

Consistency of thinking regarding what we count as knowledge and how new knowledge comes into being (epistemological concepts) as well as thoughts on what it means to be and how we become (ontological concepts) form threads that tie a research study together from intention to outcome. Although at the beginning of this study I was located in a more empirical position in terms of wanting to measure objectively in order to assess pain, the study as it stands is located within a dialectic philosophy where new knowledge is born through dialogue, has both explanatory and expressive components which give clarity and depth, and is never completely attained.

This study uses narrative as a universally understood organising principle of experience and action and also the person who experiences and acts. What we are is a synthesis of what comes out from within us, what we constitute, our 'being' impacting on the way our story is told, and as well, our response to that by which we are surrounded, what is constitutive to us, when we 'are' because we live within a certain narrative. We experience life at level of chemicals and sensing [prefiguration or mimesis1]. Meaning may be interpreted by analysing our ordering of experience [configuration or mimesis2]. Ordering our experience into narrative form involves ordering the action, placing significance on past to explain present and show intention for the future, while we stand outside of time [emplotment]. We see another person's experience through behaviours they exhibit, including actions and words, spoken or written, and this has an impact on us [refiguration or mimesis3]. If a person doesn't share their experience through actions we cannot know their experience.

Narrative knowing is pragmatic, looking for connections within personal, group and social contexts, bringing temporal being into language, accommodating complexity and developing knowledge through dialogue. Although language is not transparent and meaning is tied to shared understandings of words, the expressive qualities of

language types such as metaphors create unlikely comparisons that give insight. Living stories are fluid but told stories are set in time. Writing separates a speaker from their words, turning talk into text which may stand alone [distanciation] and be analysed by looking at levels from structure and linguistics, to temporality, content and impact on the reader [appropriation].

3.3.1 About claiming consistency despite using elements from seemingly diverse narrative researchers

As I outlined in section 3.2, there was disparity between the narrative researchers whose work helped me to create the mix of narrative methods I used in this study.

Table 3.3.1 presents similarities as well as the differences between these researchers that may superficially appear as inconsistencies. The main points of departure are:

1. what constitutes a story (STORY)
2. the nature of the link between stories and life (LINK)
3. how influential the listener is in the production of the story (AUDIENCE)
4. the method employed in dealing with stories to elicit meaning (ANALYSIS)

Table 3.3.1 Comparison of seven approaches by narrative researchers

Researchers	STORY	LINK	AUDIENCE	ANALYSIS
Labov & Waltesky (1967)	defined by structure stands alone reportable event	stories represent reality stories were linear	audience not given credit for any influence on story production	based on the purpose of elements of structure especially evaluative statements
Gee (1991)	speech event separated from context flow can be shown in line and stanza arrangement	teller portrays social standing and perspective	does not attend to the impact of the audience	focus on oral linguistic techniques poetic characteristics of speech event show teller's intent
Agar & Hobbs (1982)	life story everything participant said had place in story	Stories represent reality	does not mention influence of audience on storytelling	content themes how participant linked content and coherence showed meaning
Richardson (1988)	personal narrative consists of what participants tell researcher	people live by stories participants in similar circumstances have similar experiences and thus a story of the group can be made transformative possibilities of story	Does not claim influence on story by audience but her stance is to 'empower' her participants	content and themes linked to social understandings critical stance
Mishler (1986b)	occur naturally in conversation to make a point shared construction between teller and listener	stories are used to illustrate, clarify, make a point, provide self-protection or status	listener influences shape of story just because of who they are and their relationship to teller	content alignment with social and cultural norms teller's purpose for telling story
Johnson & Mandler (1980)	focus on folktale form of story	structure reflected how mind organises stories knowledge handed down in an oral tradition	if a story is told with this structure the story can be more easily understood and remembered by listeners	amount of processing required by the mind measured comprehension and recall
Reason & Hawkins (1988)	An expressive form	Way of showing depth in knowledge	Audience may return a responsive story of various types	Meaning held in dialect process or telling and responding

[At this point in the thesis I have not yet revealed the actions I undertook, in terms of method, and the information I was given to work with, in terms of nurses' words. However, as the writer and teller of my thesis story and standing outside of the chronological sequencing of the words on these pages, I know how the apparent discrepancies among the narrative researchers were contained in the pragmatics of my work. I will provide a brief preview into linking these researchers' work with the content of my transcripts.

Within my transcripts and subsequent analysis I noticed:

1. many stories that fell into the structure described by Labov and Waletzky
2. these stories could also be easily written out in the line and stanza pattern of Gee
3. my participants linked aspects from their personal and professional lives to my topic similar to Agar and Hobbs 'life-story'
4. whole transcripts could be taken to be nurses' personal narratives similar to Richardson's work
5. my participants were similarly situated in their work and thus I could make a group story in the same way Richardson did
6. who I was in relation to my participants impacted on how they spoke to me which reflected Mishler's work with interviewing
7. being also a member of the group, I included my contribution to the group story from Mishler's concept of the part the audience plays in co-creating the story
8. my created group story fitted the Johnson and Mandler's folktale story structure
9. responsive stories were told within interviews and within the thesis like the expressive responsiveness of Reason and Hawkins.

The rest of this section will detail the narrative understandings and philosophical thought that will show my consistent basis for decisions made around my method.]

My methodology was a result of contribution from all of these narrative writers. Although each emphasised one aspect or stance around narrative that suited their work, I integrated elements from all of them. I think it is valuable to base a new narrative approach on a variety of previous narrative work. For me the process of journeying through options to arrive at narrative methodology together with the process of drawing on various narrative researchers' works to create my unique approach was more than playing with words, thoughts and ideas, more than a cognitive challenge. The worth of pursuing the best fit of methodology is shown in how my final narrative

concepts make sense in relation to everyday clinical nursing and the actual alignment with the words spoken by the nurses.

However, in order for my approach to narrative analysis to be considered by colleagues to be a worthwhile way of doing research, several potential criticisms need to be addressed. Consequently, I will show that using diverse definitions of 'story' is appropriate when working with several story types. Each specific definition applies to each distinct type and each type of story served its own purpose in the development of the study. I will show that the complexity of life is demonstrated in links between stories reflecting life and life reflecting stories or being constrained by stories.

3.3.2 About what constitutes a story

Even though the narrative writers I used have contradictory positions on what constitutes a narrative or story, I feel that there is enough evidence in my data to show that each had a contribution to make. At this point I will present the ideas from the narrative writers that I engaged with in coming to the workable definitions that I used in this thesis.

3.3.2.1 Ricoeur's *mimesis*¹ – *prefiguration*

Ricoeur's (1990) concept of prefiguration refers to the raw material from which a story is told. Before we gather together the words about a happening, we live that happening. Prefiguration is the stance we take towards a text before we read it; we come carrying with us all our past experiences and future expectations. Our lives fall into story form. Ricoeur progresses through *mimesis*² in terms of forming a story and *mimesis*³ in terms of the interaction between teller and audience but these concepts will be addressed later.

3.3.2.2 *Performance* – *oral speech event*

Performance stories seem to fall into two types; either seeking applause or seeking connection. Both types of performance gain control of the narrative space and are polished through retelling. Examples of performance narratives seeking applause are tall tales and jokes (Linde, 1986). Examples of performance narrative seeking connection are those that narrators use to give shape to their private experiences and have the purpose of explanation in a social setting. Bennett (1986) found women's stories did not necessarily follow the Labov and Waletzky (1967) structure. In her study, elderly women narrators tell stories about typical happenings (instead of reportable events), stories are circular (non-linear) with lengthy orientations and long-

winded asides, concentrate on contexts and circumstances (not events), delay in getting to the point and are open-ended. Performance narratives are identifiable, self-contained, repeatable and polishable by narrator and then extractable by researcher. There is no audience contribution to story-text.

3.3.2.3 Anecdote

An anecdote is a story of a happening or incident, includes actions and events and is told to make a point. Within this thesis anecdotes were presented in the Labov and Waletzky (1967) form. Uncovering the point of the story occurred through the use of Gee's linguistics. It seems to me that anecdotes follow Labov's linearity and Gee's line and stanza pattern. I think nurses tell anecdotes quite frequently and so they can stand alone in analysis or be examined in the context of surrounding conversation.

3.3.2.4 Personal narrative

Personal narratives are about "...the mundane happenings of an ordinary day and extraordinary events that mark our lives." (Langellier, 1989, p243) Personal narratives are the way the individual views their experience of something; how, why and what they did (Richardson, 1990).

Both anecdotes and personal narratives are shaped by who the story is told to, where the teller is in their own experience and the context of the telling. Yet, the content of anecdotes and personal narrative are from the teller. The teller may choose to leave out information or tell it in a different way to different audiences, but the audience does not construct the story.

3.3.2.5 Collective story

A collective story is a construction that puts together personal narratives from a group of people in similar circumstances in such a way that it portrays what it is like for that group. A collective story can empower when individuals within the group are not aware of how it is for other members of the group (Richardson, 1990).

3.3.2.6 Co-created story

A story is co-created in an exchange between two individuals who both contribute to the formation of the story. Citing interviewing as an example, Mishler (1986b) claims that both researcher and participant contribute to the story.

3.3.2.7 *Metanarrative*

A metanarrative defines the way those in power think it should be for the group. People can blindly accept a metanarrative as given, choose to live within it and adhere to it or fight against it (Lyotard, 1984).

The antithetical positions I have in the study at the moment about story are:

story stands in its own right

story is co-constituted by audience and teller

I believe that all human exchange is co-created to the extent that individual's present in a particular way to according to the listener. Nevertheless, even though the form of the presentation or the confidence of the teller remains connected to the audience, the content of the story can either be personal or co-created. I think it is possible to have anecdote type stories that fit into a structuralist approach and other narrative talk that is co-created.

3.3.3 About the nature of the link between stories and life

Narrative is one way of getting our knowledge out in the open (Mishler, 1986b). A story teller can only tell what they see and know. Stories reveal personal knowledge, that is, thoughts, feelings and experiential knowledge, and presents this information in a way to ensure the listeners know what is worth talking about and where it begins and ends (Patricia Benner et al., 1996).

“Existentially, the personal experience narrator not only acts or experiences but ‘thinks about’ his action, evaluates it, learns from it, and tells the story - not to express his values, but to build them, to create them, to remake them each time he tells his stories” (Stahl, 1983, p247). Stories are self-reflexive and the teller's values are created afresh at each new telling of the story. Storytelling is emergent arising from the complex interaction of communication resources, competence of tellers and listeners, goals of both and contextual constraints.

Stories can link between public and private worlds and can have elements of both performance and general conversation (Langellier, 1989). When studying stories we can look at how their performance is located in everyday life and we can see how stories can be in the culture of everyday talk. Because these stories are told by ordinary people, it is possible telling stories can “give voice to muted groups” and we can listen to the “margins of discourse” (Langellier, 1989, p243).

3.3.3.1 Ricoeur's *mimesis*2 – configuration

Ricoeur's (1990) *mimesis*2 refers to the emplotment of stories or configuring time. It is the process that lies between events of life and the presentation of the story. Ricoeur compares the teller making the plot of a story to Kant's reflective judgment. In making the plot, a teller gathers together the beginning, middle and end and makes it into a unity. Ricoeur sees this as similar to Kant's reflective judgment, however Ricoeur thinks that Kant fails to include the social and historical dimensions in his construct. Ricoeur then understands that lives have storied elements but in the telling of a story, the narrator organises the content for a purpose.

Kant taught that the reason why it is possible to understand the particular is because particulars are contained within universals. When we have information about the universal then we make deterministic decisions, that is, taking the universal principle and applying it to the particular. Kant's 'determinant judgement' was the application of an existing concept to a particular. When we do not have information about the universal then we have to develop it from what we already know. Kant refers to decisions that take information from the particular to surmise about the universal 'reflective judgement'. Reflective judgment was the judgment of a particular for which no concept existed (Caygill, 1995; Kant, 2004).

3.3.3.2 Constitutive/constitute

The teller is constituted by and constitutes the story (Patricia Benner et al., 1996). The word 'constitutive' is an adjective meaning "constituent, essential". The word 'constitute' is a verb meaning "to make up, form, compose". The word comes from the Latin *constitutus* past participle of *constituere* to "set up". (Webster, 2009). I conceived that 'constitutive' and 'constitute' referred to the relationship between story and storyteller that contains tension in opposite directions. Does the teller compose the story or does the teller live within a story composed by another? This dichotomy between constitutive and constitute can play out in other narrative notions held in tension such as: story and audience, story and characters, and story and meaning.

I began my approach to narrative more convinced of the 'constitute' position where the teller presents the happenings of their life in story form. Ricoeur (1979) suggests that we are in the world and we use language to express our being and describe things that we presume to exist. We experience first then have something to say. Carr (1991) claims that we live through experience and perform our actions rather than being pawns in someone else's game. People explain through narrative why something happened

(Polkinghorne, 1988). People construct meaning by structuring their experience into coherent accounts, in sequence, across time, which we call stories. This is how they make sense of life. This creating of stories provides continuity and meaning and is the context in which life events are interpreted (M. White & Epston, 1990). However, now I believe that both 'constitutive' and 'constitute' occur in relation to tellers and stories.

When considering the ontological question of the teller's 'being' in relation to story, I thought:

1. we 'are' the stories we tell - we live stories
2. we 'are' apart from narrative - we order our experiences into story form in order to explain or express
3. we 'are' under the control of narrative - we are controlled by the stories we live within

Elements of all three positions are present in this study, for example, we live stories and are controlled by stories we live within as nurses when we go about our work.

What we do and think is our story and what we are told to do or the expectations we live within is the story that can control us if we are compliant with it. We order our experiences into story form when we tell of incidents to explain or emphasise a point, thought or idea.

Narrative displays the goals and intentions of human actors; it makes individuals, cultures, societies, and historical epochs comprehensible as wholes; it humanizes time; and it allows us to contemplate the effects of our actions and to alter the directions of our lives (Richardson, 1990, p117).

Narrative is the organising principle not only of experience and action but of the person who experiences and acts. Personal identity is related to the coherence of a life story (MacIntyre, 1981). Therefore, people use stories as an everyday way of expressing themselves. They show chronology and context of events and meanings for storytellers and, in addition, reflect cultural themes and values (Stevens, 1993). Stories convey shared beliefs and values at a cultural level and identity and direction at an individual level (Polkinghorne, 1988).

Narrative recognises the meaningfulness of individual experiences by noting how they function as parts in a whole. Its particular subject matter is human actions and events that affect human beings, which configures into wholes according to the roles these actions and events play in bringing about a conclusion (Polkinghorne, 1988, p36).

Connelly and Clandinin (1990) talk about the scene of narrative as a place "...where the action occurs, where characters are formed and live out their stories and where cultural and social context play constraining and enabling roles." (p8) The context of a story goes beyond the scene within which the characters move, to the wider realm of cultural

values, social setting, and politics. It is influenced by where the teller is within their own life story and what telling the story does to their identity. Our stories tell us who we are and who we can or cannot be and thus raise questions about power, knowledge, ideology and identity.

Human experience can only be understood within a whole which gives it meaning (H. G. Gadamer, 1975). The framework for this whole is the lived story (McIntyre, 1985; Sarbin, 1986). People tell stories and play a part in other stories; several stories can be simultaneous (Tappan, 1989). The whole of a person's life is made up of beginning-middle-end, means-end, suspension-resolution as are individual narratives (Carr, 1991).

Mishler (1986b) recognised the complex nature of stories when serving a purpose within an interview context for self-protection, status maintenance, identity formation of the teller to the audience. Stories are a form of self preservation where the narrator claims a particular kind of self identity, making comments about the kind of person they are, and within the story confirms and validates this identity. Therefore, stories are used to develop and maintain a sense of identity (Viney & Bousfield, 1991). "Almost invariably, first person narratives demonstrate that the protagonist is a good person, behaved correctly, did the best that could be expected in the circumstances. Even in narratives which purport to show some bad action of the speaker, there is a split between speaker and protagonist, so that the speaker is shown to be a good person who recognises what the protagonist did wrong." (Linde, 1986, p187)

Stories can be seen as 'political praxis' where practical application of knowledge or habitual established practice happens within a power dynamic (Langellier, 1989). Stories portray normative structures of social action and cultural values (Mishler, 1986b). Stories may or may not align with the metanarrative [also known as social/cultural story, explanatory system, discursive field, ideology, dominant story, culturally shared myth or organising device]. Metanarratives can be seen, for example, within a workplace, organisation or social group.

If the personal story is not aligned with the metanarrative, then the person may choose not to tell their story by going underground, to tell it to only select audiences, for example a select gender, or to 'rock the boat' by endeavouring to reconstruct the metanarrative through emancipation or transformation. When nurses' stories do not fit with the dominant script, most nurses take their stories underground, in order to

prevent devaluation and maintain personal integrity. Nurses need to be empowered to tell their stories (Parker, 1990). Sometimes a story can be used to tell those things that are hidden in the metanarrative. The new story offers a new perspective and possibilities for solving problems (Judy Lumby, 1995).

When Lumby (1995) asked nurses to tell stories of advanced practice, she heard stories about moral and ethical issues, which are usually silenced and which cause conflict for nurses or patients [through issues of insurance and liability], rather than stories of procedural or technical activities or political issues such as efficiency. "People whose narratives are heard within a community may be better able to contribute to constructing how that community sees itself and its problems." (Viney & Bousfield, 1991, p758) Although the culture of nursing encourages storytelling, empowerment can only occur if storytelling is carried out within a context of trust and collaboration (Judy Lumby, 1995).

If the story is aligned with the metanarrative it is possible that things that do not fit with the dominant story have been pruned (M. White & Epston, 1990). Gee (1989c) suggested that culturally shared myths are used as organising devices in stories. He shows how this process can be constitutive, when, for example, the lower class internalise norms of the middle class and apply them against themselves, cooperating in their oppression. Background assumptions about the world are evident in the explanatory system of the narrative. These assumptions permit the existence of the events of the story and the understandings of the narrator. Within this system, referring to values and norms, storytellers make moral comments about the way things are, the way things ought to be (Linde, 1986). How many explanatory systems are there? How many can one person use? How much is the speaker committed to the system? How are popular explanatory systems derived from expert ones?

Mumby (1987) looked at stories told in the organisational setting of IBM in order to find how they relate to the metanarratives of the organisation. "...how a particular narrative, or cluster of narratives, might function to enable or constrain behaviour within the context of certain ideological meaning formations. The degree to which a story demonstrates a transformative or emancipatory capacity suggests its relationship to dominant ideologies." (Mumby, 1987, p124) Mumby concluded that "...there is no simple correspondence between power, ideology, and narrative. It is too simplistic, for example, to assume that a particular narrative cluster asserts a consistent, monolithic organisational reality; such an analysis must regard the cluster in the context of other

clusters, relevant organisational practices, conflicting sub-cultures, economic conditions, and so forth.” (p125). Therefore, we can look at whether the storyteller is adhering to or resisting dominant stories, but there are many other factors involved in the complexity of power and politics.

Cazden and Hymes (1978) propose that “...one form of inequality of opportunity in our society has to do with rights to use narrative, with whose narratives are admitted to have cognitive function” (p21). Mumby (1987) agrees by claiming that “...storytelling is not a simple representation of a pre-existing reality, but is rather a politically motivated production of a certain way of perceiving the world which privileges certain interests over others” (p114). Stories we tell can legitimate dominant forms of reality. Therefore, there are unequal distribution of storytelling rights among groups in society. We can check the political connection by asking “Whose interest does a personal narrative serve?” Amy Schuman (1986) explains the power that is around storytelling in terms of ‘rights’:

1. entitlement – who is allowed to tell stories and who is allowed to listen
2. tellability - what stories bear telling and who decides
3. storyability - when is it appropriate for a certain person to tell a certain story

Even though narrative is claimed to be a legitimate source of knowledge (Lyotard, 1984; Polkinghorne, 1988; P Ricoeur, 1980), Cazden and Hymes (1978) maintain “...one form of inequality of opportunity in our society has to do with rights to use narrative, with whose narratives are admitted to have cognitive function” (p21). Mumby (1987) claims that in meaning formation, stories that uphold dominant forms of reality can lead to ‘discursive closure’ which restricts the interpretations and meanings that can be attached to an activity. This results in distortion, marginalisation and misrepresentation of particular groups so that certain realities hold sway over other competing realities.

Foucault (1976) defines ‘discursive fields’ as relating language, social institutions, subjectivity and power. Weedon (1987) claims, “Discursive fields consist of competing ways of giving meaning to the world and of organizing social institutions and processes. They offer the individual a range of modes of subjectivity. Within a discursive field, for instance, that of the law or the family, not all discourses will carry the same weight or power” (p35). Stories are told to share meaning within ‘discursive fields’ using language subjectively and responding to the power that is in place. However, how the story is heard will also depend on those same ‘discursive fields’.

Carr (1991) raises the point that if stories are ‘constitutive’, then authorship and authenticity may not belong to the teller, however, while the teller may not write the story, they choose the story in which they function as a character. The place of power and emancipation allow for choice. Even if the story has already been written by the dominant culture and the part the teller is playing has been played before, storytelling can also be a way to break free.

Stories are ‘constitutive’ when the teller’s experiences are restricted by the metanarrative in which they live, for example, we can be restricted in our behaviour if we live according to the nursing metanarrative that tells a story of subservience to doctors. Stories ‘constitute’ when they represent the experience of the storyteller.

3.3.3.3 *Temporality and emplotment*

Because there is a distinct beginning, middle and end, stories have a temporal nature. Human time only exists in stories and stories only exist within time. Standing outside of their stories allows tellers to use time as an ally.

We are following therefore the destiny of a prefigured time that becomes a refigured time through the mediation of a configured time (Paul Ricoeur, 1990, p54).

I constructed Figure 3.3.1 as a drawing of time, experience and movement and how this relates to stories. The diagram is further explained below:

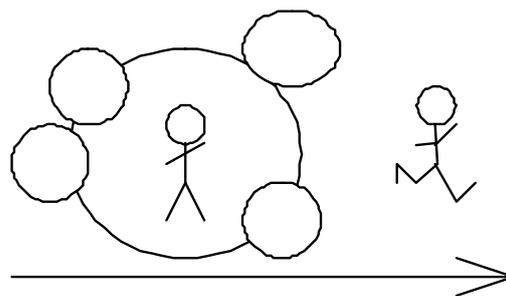


Figure 3.3.1 Depiction of the movement of time in relation to telling of experience in the form of ‘story’

Stories tell us about experience by attending to context and temporality (Connelly & Clandinin, 1990). The central circle surrounding the person in the diagram represents experience. Stories show us the person of the storyteller through the knowledge and concepts relayed and the self-identity formed within the story by the storyteller for the audience (Mishler, 1986b). The person inside the circle represents the person of the storyteller. Stories help to sustain communities through the playing out of

interdependent roles, maintaining coherence, creating group identity (Linde, 1986), and learning from the past through multiple perspectives (Patricia Benner et al., 1996). The other circles impacting on the central circle represent the community. However, life moves on (Plummer, 1983) and stories are not meant to be caught and held. The arrow represents the movement of time. We edit our stories as life moves and changes (I. Robinson, 1990). When stories are recorded or written they are frozen, no longer fluid. The reader must understand that because of changing context and time marching on, the story may be different now (Connelly & Clandinin, 1990). The person leaving the scene represents a change in their story from what was told when in the circle.

Because narrative is particularly sensitive to the temporal dimension of human existence, it pays special attention to the sequence in which actions and events occur (Polkinghorne, 1988, p36).

Narrative attends to and grows out of temporality. As humans, we do not experience time as a “succession of instants” or “linear linking of points in space” (Richardson, 1990, p124). Experiences have a temporal structure even though the object of the experience may not be temporal, for example, feeling or seeing a statue is an event with duration; a beginning, middle and end (Carr, 1991). Narrative is one way individuals or groups explain experiences of temporality by organising experiences into temporally meaningful episodes; linking the past, present, and future. Narrative contains the universal human experience of time, both in its content and sequencing. Time is made human (Carr, 1991; Polkinghorne, 1988; Richardson, 1990).

Hegel (1977) asserts that, “...narrative is our primary (though not our only) way of organizing our experience of time...” (p110). Stories represent the way time happens in our lives in terms of beginning, middle and end, but also means-end and suspension-resolution. “...narrativity is the mode of discourse through which the mode of being which we call temporality, or temporal being, is brought to language” (Carr, 1991, p99). Forster (1927, p44) connects stories to daily life through how we conceptualise time. “We think one event occurs before or after another”, although “when we look at our past, it does not stretch back evenly but piles up into a few notable pinnacles” Forster claims this is because we have a double allegiance “...life in time and life by values. ‘I only saw her for five minutes but it was worth it.’”

Narrative involves gathering together events into a plot where emphasis is placed on events that contribute to the theme of the story (Polkinghorne, 1988). What is essential to narration is that it portrays certain points of view on a sequence of events.

“Reciprocally, a plot is a way of connecting event and story. A story is *made out of* events, to the extent that plot makes events *into* a story.” (Paul Ricoeur, 1990, p106)
[Ricoeur’s emphasis.]

Ricoeur (1990) defines the following temporal functions of narrative:

1. Narrative locates us ‘within-timeness’ [which is a concept Ricoeur attributes to Heidegger] - not abstraction of linear time, for example, ‘then’, ‘earlier’, ‘later’, ‘have or don’t have time to do something’, time can be ‘lost’ or ‘won’, then there may be references to day and night or seasons.
2. Narrative moves us from within time, ‘reckoning with’ time, to historicity ‘recollecting time’ - plot groups thoughts, themes and point together to make a whole instead of mere succession. Plot thus allows an ending instead of openness of mere succession.
3. Narrative allows repetition [the storyteller *is* who he *was*] – in regards remembering (Paul Ricoeur, 1990, pp107-109).

There are different points of view on the sequence of events. Paul Ricoeur uses the term ‘emplotment’ to connect events within a story by “grasping them together” towards a conclusion resulting in a “point” or “theme” (Paul Ricoeur, 1990, p105). The emplotment of a narrative composes meaning out of events and displays human values (Polkinghorne, 1988). According to Aristotle (2004), the plot (*muthos*) organises events in order to construct wholeness. The narrator determines the beginning of the story, not as a place where nothing has happened before, but where the events begin that are of importance for what follows. A succession of events follow until the resolution of the adventure is complete. The plot gathers from chronological events and forms them into a meaningful story, similar to a commentary versus a news report (Polkinghorne, 1988). Plot shapes events into a story (Paul Ricoeur, 1979). The actual form the telling of a story takes is ordered by the point or the concerns of the teller (Patricia Benner et al., 1996). Plot is the structural part of the story that shows the intent or meaning through sequencing the events over time. It is not usually until the end of the narrative that the meaning becomes clear (Brooks, 1984).

Even though narratives attend to the passage of time, the narrator has authority over characters and audience. This authority comes from the teller being free from the constraints of time, standing outside or above events. The teller can create a disparity between order of events and order of telling, flashbacks and flashforwards. Sequencing is used to stress a point of view (Carr, 1991). Especially when stories occur within

interaction, the concept of linear temporality becomes inadequate as participants talk of what has happened or what might happen, and thereby construct a narrative which combines past and possible future (Beach & Japp, 1983).

Temporality connects significance to past, value to present and intention to future (Connelly & Clandinin, 1990). Depending to whom the story is told, the past is brought together to explain the present in a variety of ways. "Past events and experiences in narratives are generally reconstituted and linked together in a form which leads to, explains and is immediately conditioned by the present" (I. Robinson, 1990, p1179). For example, telling a story about an operation in the past explains the ability to empathise with those undergoing an operation today.

Beach and Japp (1983) show that stories are not linear when they refer to talk in stories being about what has happened to what might happen. "How storifying involves the active utilization of both past experiences and future possibilities as here-and-now meanings are created and sustained through interaction. It is our contention that here-and-now meanings could not exist without past and future counterparts, and that storifying is the vehicle through which interactants time-travel together" (Beach & Japp, 1983, p873)

The Chicago School in sociology in the 1920's and 1930's believed that experience was not static but flowed, evolved, emerged, changed and was precarious (Plummer, 1983). So meaning in stories is also emergent, full of ambiguity and constantly being negotiated (I. Robinson, 1990). However, the writing of narrative freezes a story in time, whereas stories are retold and lives relived. Even if a story is written in such a way that it conveys a sense that the narrative is unfinished or ongoing, the readers may freeze it (Connelly & Clandinin, 1990). In terms of rigour, how does the story frozen in time contribute to practice? Does meaning live on? Writing a story freezes it but there may be times when an oral telling of a story becomes frozen in time because there is no further opportunity to retell the story later.

The inherently temporal nature of stories allows narrative researcher to bring the experience of time into the theory and practice agenda (Connelly & Clandinin, 1990). People use the experiences of the past to negotiate the future. Stories told now are influenced by past adventures (Scheibe, 1986).

Human experience is bounded by time and narrative attends to this dimension. In addition to what the past has taught and what is intended for the future, the plot of a story brings together significant memories of the past to explain the present or show what is currently valued. This bringing together in the plot does not necessarily follow a linear time line and may vary for different audiences. As time moves on, stories change.

3.3.3.4 Oral and written language

Stories are situated between written and oral modes of communication (Langellier, 1989). Narrative is an approach that relies on language as the primary medium of discovery and explanation. Although language is fraught with ambiguities leading to potential misunderstandings, language is also packed with fascinating linguistic elements that can add layers of meaning.

...language takes up the contingencies of existence, and the perceptual openness of life to the natural and intersubjective worlds, and moulds them into a meaningfulness that is greater than the meaningfulness they originally hold. One of the ways language does this is to configure these givens into a narrative form in which desires and aspirations are used to transform the passing of life into an adventure of significance and drama (Polkinghorne, 1988, p31).

Access to other people's experience can only be via the minefield of language (Riessman, 1993). Language imposes form on structures of meaning through linguistic forms which filter and organise information (Carr, 1991). Because language is the vehicle through which we both communicate within narrative and interpret meaning, problems with opacity and distortion versus transparency of language have been raised. Gee (1989c, pp91,92) understood that meaning is more complex than "...something that is packaged in nice little bundles (words and sentences) and conveyed down a little tube-like channel to someone else who simply undoes the package and takes out the morsel of meaning." Instead, within narrative analysis, it has been more helpful to conceptualise language as a lens through which we are able to see experience and find meaning (Polkinghorne, 1988). In fact, language is always something that is worked with in context by both speaker/writer and hearer/reader through a complex inferring from the structural properties of the language.

Merleau-Ponty (1962) proposes that thought and language cannot be disconnected from human experience. Understanding of language begins with speech and the use of spoken language constructs new meaning as fresh and new usage occurs. Meaning can be found when language is examined in relation to perception, silence and truth (H. Schuman & Presser, 1981). Narrative meaning is clear when language is understood

as a display rather than a reflection or a distortion of meaning. Sceptically, language can be transparent or distorting. However, a third alternative is that language may be a lens which enables experience to be brought into focus (Polkinghorne, 1988).

Rorty (1979) thought that we should stop looking for ultimate truth and start participating in dialogue. He wrote, “To see keeping a conversation going as a sufficient aim of philosophy, to see wisdom as consisting in the ability to sustain a conversation, is to see human beings as generators of new descriptions rather than beings one hopes to be able to describe [reality] accurately” (Rorty, 1979, p378). If language is conceptualised as a lens through which we are able to see experience and find meaning, then we will be motivated to find common-to-all and useful forms of language that will then enable the conversation to continue. The dialogue or conversation being what we undertake in research and the dissemination of findings leading to an interplay of ideas. The lens will also be constantly reshaped in order to accommodate what we look at through flexibility of meanings attributed to the language we use. Having a sophisticated language for academics and straightforward language for clinicians inhibits the conversation between us. Within this research I have attempted to find a common language so that it is understandable to both academics and clinicians.

However, we need to be aware that the meaning of language terms are formed from original ideas [etymology] and changing the meaning attributed to language terms may lose the original idea behind that term. In linguistic philosophy the emphasis is less on what words mean and more on the meaning inherent in how words are used (Nelson, 1993; Stone, 1965). We must realise that when finding meaning within dialogue, the meaning that we arrive at will again provide a basis for the next dialogue where parties to that dialogue reform the meaning for themselves. This process is in itself dialectical. The implications of changing meanings of terms through the process of dialogue is an area for further research.

Language forms function to impose structure on meaning. Linguistic forms filter and organise information and thereby transform it into meaning. Coherence in narrative is produced using principles of phonetics, rhyme, and metaphoric connections (Polkinghorne, 1988). Literary devices, for example metaphors, are often used for the communication of cognitive content. Metaphor exists at the conceptual level, for example, experiencing arguments as combative, “He shot down your positions” or “I won” rather than a dance. Facts make sense in terms of their place within the

metaphor. Idea or enlighten is a light-based metaphor in research (Richardson, 1990, p124).

...language is not a set of formal classes or boxes but... a medium in which we exist... Thus every attempt to design experiments that deal with generic question form flies in the face of the fact that every question is unique. Experiments on form seek to draw generalizations from a material that resists generalization, that is particular and plastic and seamless. This may well be the greatest obstacle of all." (H. Schuman & Presser, 1981, pp310-311)

Because language is opaque, actively constructed in a context, and imposes form on experience, the argument against narrative analysis as a research methodology is that distortion can occur when we use language as the vehicle through which we both communicate within narrative and interpret meaning (Carr, 1991; Riessman, 1993). However, when we use language new meanings are also possible as new usage occurs and fresh meaning is constructed (Merleau-Ponty, 1962).

Ricoeur (1984) separates written and spoken word because he believes writing separates meaning from the speech event [distanciation]. Writing sets in concrete the 'said' of speaking and removes the speaker. Writing also frees the text from any intention of the author that is not part of the text [configuration]. When read, a text stands alone; readers can read it more than once and discuss what they read with others [refiguration]. There are rules governing the shape of writing and thus, the author shapes the writing in addition to trying to convey meaning.

Plato (1892) argues against writing because he believed writing made us more forgetful even though it appears to be wise and resemble reality. However, Plato wrote down the philosophy of his teacher, Socrates, who may have been illiterate. Socrates' view was that writings are indifferent to the person reading them. This fable recorded by Plato and told by Socrates about 2,500 years ago portrays the effect of writing on memory:

At the Egyptian city of Naucratis, there was a famous old god, whose name was Theuth. He was the inventor of many arts, such as arithmetic and calculation and geometry and astronomy and draughts and dice. But his great discovery was the use of letters.

Now in those days the god Thamus was the king of the whole country of Egypt. To the king came Theuth and showed his inventions. King Thamus enquired about their several uses, and praised some of them and censured others, as he approved or disapproved of them. Then they came to letters.

Theuth said: Using letters will make the Egyptians wiser and give them better memories. It is a specific both for the memory and for the wit.

King Thamus replied: O most ingenious Theuth, the parent or inventor of an art is not always the best judge of the utility or inutility of his own inventions to the users of them. And in this instance, you who are the father of letters, from a paternal love of your own children have been led to attribute to them a quality which they cannot have.

For this discovery of yours will create forgetfulness in the learners' souls, because they will not use their memories. They will trust to the external written characters and not remember of themselves.

The specific which you have discovered is an aid not to memory, but to reminiscence. You give your disciples not truth, but only the semblance of truth.

They will be hearers of many things and will have learned nothing.

They will appear to be omniscient and will generally know nothing. They will be tiresome company, having the show of wisdom without the reality.

source: Phaedrus, Plato (360 BC) (trans, Benjamin Jowett, 1892)

The true discourse, Socrates says, is that which is inscribed in men's souls [sic], and is delivered through speech. In Plato's dialogue *Phaedrus*, Socrates attacks the idea that writing is the best way of communicating ideas. He says that, as with paintings, you might get the impression that words could answer you back, but instead both remain solemnly silent (Plato, 1892)(Phaedrus, 275d-e):

'You'd think they were speaking as if they had some understanding, but if you question anything that has been said because you want to learn more, it continues to signify just that very same thing forever. When it has once been written down, every discourse rolls about everywhere, reaching indiscriminately those with understanding no less than those who have no business with it, and it doesn't know to whom it should speak and to whom it should not. And when it is faulted and attacked unfairly, it always needs its father's support; alone, it can neither defend itself nor come to its own support' (Plato, 1995, p81)(trans. Nehamas and Woodruff)

Ricoeur (1976) comments on Rousseau and Bergson's work by saying that they argue that writing breaks up the presence of oneself to another. Presence between teller and listener is required for verbal communication. Therefore writing leads to separation of people which in turn leads to tyranny and inequality. Ricoeur, himself, rejects reflection on writing because it assumes author and reader share a similar relationship to participants in a conversation, but the immediacy of understanding and explanation are not available. 'Written texts stand apart temporally and intentionally from the immediacy of dialogue.' (Paul Ricoeur, 1981, p24) Curiously, in our current world of contemporary instant technological, written communication is returning people to community that is more closely aligned with oral cultures.

Variation in language is used to demarcate social identities. There is a trade-off between using language to promote status in terms of being in the position of 'master' and being admired, or showing solidarity by being content to be viewed as a peer and being content to be like the rest. The trade-off between these two positions depends on the teller's social group. Using language this way leads to construction of the teller's identity. The social perspective taken by the teller towards the listeners is located in the intonation, in addition to the words and grammar used in stories (Arndt, 1992).

There is interdependence between the telling of the story and the happenings of which the story is told. Analysis of the storytelling performance event is made through attention on how the story is told and how it compels listeners. Oral storytelling occurs in a social situation (Bauman, 1986). Wolfson (1978) demarcated narrative performance features: conversational historic present, which is the use of present tense to refer to past events in conversation, direct speech, asides, repetition, expressive sounds, motions and gestures. "Performance is only given when norms for evaluative interpretation are presumed to be shared" (p225). A person with lower status may tell a story but except under very unusual circumstances it is not appropriate to perform it. Performances rarely occur in research interviews but if they do it would depend on shared identity of interviewer and interviewee.

3.3.3.5 Interpretation of meaning

Story has both elements; event and meaning (P Ricoeur, 1976). Interpretation of experience involves the process of language as well as the order of meaning. Narrative is a way of expressing meaning (Polkinghorne, 1988).

Riessman (1993) described a three-fold schema of interpretation. Life-as-lived [what actually happened], life-as-experienced [images, feelings thoughts, meanings held by the person whose life it is] and life-as-told [narrative] are three different entities. When an investigator accesses the life-as-told, the act of telling reconstructs the experience through meaning which comes from the interaction between the participant and investigator (E. M. Bruner, 1986; Riessman, 1993; Sandelowski, 1991). Finding meaning in language and behaviour comes through interpreting what is heard and seen. Interpretation occurs at the level of the participant telling, when the investigator listens, then reads and analyses the transcripts, finally the reader interprets when presented with the research report (Riessman, 1993).

Various problems are encountered in the study of meaning. Meaning has a complex organisation and direct access is only available to our own realm of meaning, requiring introspection that may be limited by time and repression. The realm of meaning is expressed through language which is context sensitive and loses information when treated in isolation. Furthermore, hermeneutic reasoning, used to analyse linguistic data, does not produce certain and necessary conclusions. Meaning is an activity, not a thing therefore it is not static and not easily grasped. (Polkinghorne, 1988).

The dichotomy of distance and intimacy in story telling allows narrators the space to reflect on their actions, individually interpret them, then connect with common experience (Churchill & Churchill, 1992). In 'reader response theory' the situation of being mid-story, similar to when a person is halfway through a novel and they know some of the experiences of the characters, what has happened in the story before, and has anticipations of what might happen, reflects the place of the storyteller in relation to their life. The life is not yet complete and therefore endings are ambiguous. The teller is then thought of as reader of their own story (B. J. Good & Good, 1994). In my research the participants are in the midst of the story, trying to determine how it is progressing and how it might turn out. They even make suggestions to improve the story. It is through the common experience that listeners, or readers, are able to recognise their stories in the stories of the narrators (Polkinghorne, 1988).

Ricoeur (1976) defines interpretation as understanding the intention of discourse, including ideological bias and promotion of ideas and explanation of the structural form the words are in, including the historical context. Levels of interpretation occur both within the storyteller and the audience with a goal of interpretation to share our insights with each other. Researchers carry a responsibility to show their method of interpretation within the research. The interpretive process is never completed otherwise the text would be rendered consumed and empty.

Polkinghorne (1988) sees reality consisting of three realms; the material, organic, and mental realms. "Narrative meaning is one of the processes of the mental realm, and functions to organise elements of awareness into meaningful episodes."(p1) He goes on to claim that narrative is the primary form by which human experience is made meaningful.

Narrative meaning is one type of meaning produced by the mental realm. It principally works to draw together human actions and events that affect human beings, and not relationships among inanimate objects. Narrative creates its meaning by noting the contributions that actions and events make to a particular outcome and then configures these parts into a whole episode (Polkinghorne, 1988, p6).

Relationships and connections within the realm of meaning include:

1. One perception is the same as or not the same as another.
2. Similar or dissimilar to another
3. An instance of another
4. Stands for the other
5. Is part of the other
6. Is the cause of the other (Polkinghorne, 1988, p4)

Searching for understanding in this study involved gathering words from written texts to oral speech yet the words in and of themselves would not provide the insight and satisfaction to my questions without those offering the words endowing them with meaning and me as receiver also attributing meaning. Meaning involves gaining a sense, grasping intent, feeling the import, knowing the gist from the words offered or received. Working with words to gain understanding has been undertaken using many methodologies underpinned by accompanying philosophies. Before sitting comfortably with narrative analysis as methodology for this study I walked through a number of other ways of searching out insights and answers as outlined in section 3.1.

At the very basic level, constantly happening inside of us and unavailable to the outside world are sets of chemical and electrical events in the form of energies that produce, or perhaps reflect, what it is that we are thinking and feeling. [chicken and egg dilemma] Levels exist from strong and intense to mild and mundane. We may name this 'experiencing' life. The energy of these thoughts and feelings is connected to what sense we make. The word 'sense' represents what our senses bring to us to consider and then somehow we order, file or connect parts into a whole or link similarities. This sorting process hinges on what the experience means to us. Meaning is shown in how we sort [we can look at our meaning though what we have done with what we have received] and meaning drives the sorting [knowing what the received means to us determines what we do with it].

Although these energies are internal, what is happening in us is not entirely hidden in that unseen energies connect between individuals, external appearance in posture and movement also indicate internal happenings. Intense internal happenings may result in more physical indications such as those activities which indicate emotion. Again certain physical actions are connected with certain meaning and this can vary across cultures or even amongst individuals. Intentionally making our experience available to others usually involves words. Yet unresponsive patients are not able to speak.

Unlike the objectivity of experimental research, the search for meaning within narrative research demands the use of words and interpretation of those words. The storyteller has space within a story to reflect on and interpret their experience, when an investigator accesses the story, interpretation occurs as the investigator listens, then reads and analyses the transcripts, finally the readers interpret and may be able to recognise their stories in the research report (E. M. Bruner, 1986; Churchill & Churchill, 1992; Polkinghorne, 1988; Riessman, 1993; Sandelowski, 1991). Therefore, interpretation occurs on multiple levels.

Ricoeur (1976) found the question 'what is meaning?' a fundamental post-structuralist issue. He claims that the meaning of 'meaning' is the speaker or author's intent; what is the inner significance of something, what we want to convey by our words or actions. I talk to nurses, they tell me words, I write down the words, I analyse those words to find meaning - I am trying to find what the nurses were wanting to convey by their words or the actions they describe; I am trying to find the inner significance of this nursing situation. Similar to reading between the lines, if one of the participants keeps asking me if they are on the right track, I can take that to mean that the participant sees me as an expert and approaches the interview as a quiz rather than understanding I value their knowledge and experience as unique and invaluable to my research.

I use the knowledge that I have about how stories work to interpret participants' words and show what I think was meant. In turn, the reader of my thesis uses their knowledge to interpret what I have written and find meaning for themselves. Meaning is the 'in here' and words or actions are the 'out there'. So there is meaning within the nurses [in here] that they try to give to me through the avenue of a story [out there], I try to find that meaning by letting their words have an affect on me [in here] and then express the collective meaning I come up with in the collective story and further discussion of the thesis [out there]. The reader of the thesis finds their own meaning by letting the written word meet their own knowledge and experience [in here].

3.3.3.6 Truth claims

Stories are situated between fact and fiction (Langellier, 1989).

Jerome Bruner (1986) claims narrative to be one of two complementary cognitive reasoning modes, the other being logico-scientific. The logico-scientific mode looks for universal truth, abstracted from spatial and temporal contexts, whereas narrative looks

for connections between events, within context. Narrative explanation is different to logical reasoning because the explanation and prediction cycle is broken. Instead, it clarifies the significance of events on the basis of outcome that has followed (Polkinghorne, 1988).

Although, many scholars have argued for narrative as a legitimate source of knowledge (Polkinghorne, 1988; Paul Ricoeur, 1979; 1981; 1986, 1990) [refer Appendices B and L], others seem to want to hold onto the logico-scientific way of thinking whilst also doing narrative research. For example, Culler (1981) looks for the 'real' truth within narrative by making a distinction between story as a sequence of events and discourse that orders and presents those events. Wanting to find the truth, Culler has to decide whether either the events really happened the way the story is told or the discourse is designed to make it seem so. Whereas, Smith (1983) suggests the existential significance of personal narrative is not resolved by decisions about whether an incident is true or whether it involves real people but how it produces meanings which count as real or true.

I have devised a chart using thoughts from Bailey (1996), Connelly and Clandinin (1990), Crites (1986), Guba and Lincoln (1989), Kuhn (1970), Linde (1986), Lumby (1995), Messick (1989), Mishler (1990), Polkinghorne (1988), Robinson and Hawpe (1986) and Van Maanen (1988) to show the nature and direction of arguments between foundational knowledge relying on logico-scientific thought processes, and pragmatic knowledge relying on narrative thought processes, and how the nature of 'being' relates to stories. [Refer Appendix L]

The plot of a narrative is constructed using a reasoning process called 'abduction'. This process is about suggesting a hypothesis that can explain puzzling phenomenon. During this process, interaction takes place between a construction that might explain connections between events and resistance of those events to fit the construction (Polkinghorne, 1988). If we examine events backward and forward temporally, they may appear deterministically related. Connelly and Clandinin (1990) go on to suggest "If not causality, what then? Narrative explanation derives from the whole. Narratives are not adequately written according to a model of cause and effect but according to the explanations gleaned from the overall narrative" (p7) "change from 'beginning' to 'end'" (p116).

Narrative explanation results when there is a recognition that an event is a human action, not just a physical occurrence, the intentions are acknowledged as the impetus for action and has a structure “one because of the other” (Polkinghorne, 1988, p172). Although Connelly and Clandinin (1990) caution against looking for causality in narrative, preferring whole explanation, Polkinghorne (1988) considers this notion of “cause” is important because recounting the connection between events and actions that have led to an outcome results in an appropriate statement of the reason for the event. “The connections between the events constitute meaning” (Richardson, 1990, p118). A narrative is explanatory if it is comprehensively coherent, nothing relevant omitted and nothing irrelevant included. Atkinson (1978) suggests three requirements of coherence; should be intelligible, unified subject matter, and causally related (p131).

Hannah Arendt was a German Jewish political philosopher, a contemporary of Heidegger and Kant. Towards the end of her life Arendt wrote a series of lectures on Kant. In Kant’s ‘Critique of Judgement’ (2004) he differentiates between ‘determinant’ and ‘reflective’ judgments. If the ‘universal’ is given and the ‘particular’ is found to be part of the universal then the judgment is determinant [also cognitive]. This concept relates to the logico-scientific stance. If the particular is given and the universal has to be found for it then the judgment is reflective [not cognitive]. This relates to the narrative stance. He sees ‘reflective judgement’ as being able to move from the particular to the universal without reference to cognition or rules, reasoning about particulars as they relate to the universal. For example, a particular flower or landscape can be an example of the concept of beauty as a universal.

Arendt explicates the concept that the universal can be known within the particular; individual stories can highlight situations commonly experienced by those within the group. Arendt thought the ‘exemplary validity’ of Kant, where an example attends to the particular and illuminates the universal, is the best way to traverse the gap between the particular and the universal (Beiner, 1982). This notion of the universal singular is reflected in the relationship between personal narratives and social discourse where every story is unique but also representative of others’ stories, especially where the context is similar (N. K. Denzin, 1986; Norman K. Denzin, 1987; I. Robinson, 1990; Williams, 1989).

In response to Kant’s philosophy on judgment, Arendt thought that it was only the spectator that would be free to make judgment. Only the spectator could be impartial, disinterested, free and autonomous because the actors were concerned with the

opinions of others, although Arendt concedes that the critic and actor reside within everyone. In view of her position on the particular's relationship with the universal, Arendt suggests offering examples [particular] will support the validity of an opinion more than advancing reasons [universal] because advancing reasons fuels arguments whereas offering examples encourages the listener to imagine themselves in situations they have never experienced before (Beiner, 1982).

3.3.4 About the influence of the listener on stories

Stories are situated between literary and social discourse (Langellier, 1989). When we consider the interaction of listeners in the process of storytelling, the unit of analysis shifts from teller and story to story and listener. "How does a particular narrative, or cluster of narratives, function to enable or constrain behaviour within the context of certain ideological meaning formations?" (Mumby, 1987, p124) Participants not only operate as interactional partners in conversation, but they also enact their social roles in relation to each other. Tellers also posture themselves for their listeners. An example of story to listener interaction is when a narrative depends on the gender of tellers and hearers.

I found it curious that nurses' anecdotes in transcripts had the same shape as stories told to white male researchers [Labov and Waletzky] by young urban black males in the USA. Maybe it is because both listeners were researchers! And stories told by children in show and tell at school have the same Gee linguistic devices as anecdotes told to me by my colleagues. Are these forms universal or reliant on audience? However, I do believe that the audience shapes the story because for me it rings true. I would tell my birth stories, for example, differently to a close friend, who was also a mother, than to someone who casually asked me at work and who had not given birth. I wondered whether differences in the story because of the listener would be in content or form. The form helps structure the meaning in the content.

When I adopt the stance that the audience is intrinsic in the expression of the story in the present, what does that mean for the stories I have been told? I, as audience, am colleague, mostly higher in status in the nursing hierarchy, 'pain expert', researcher, so what is told to me is influenced by those perceptions. What is contained in the transcripts may include nurses defending their practice from possible critique by me rather than just sharing. The content certainly is more focussed than a tearoom chat because of my explicit area of interest. If I had talked to other nurses in a different setting, at a different time, the stories would have been told differently.

Polanyi (1985) “Speakers tell stories in conversation to make a point” (p87). There is entrance and exit talk. The conversational setting seems to be seen as the container of the story, the talk in which the story is told. The point of the story is known or negotiated among participants against a background of already constructed values. Sacks (1986) and Jefferson (1978) portray storytelling in conversation as suspending turn-taking rules but the longer turn is neither extensive nor unbroken. Stories are usually introduced before their actual telling, the listeners indicate consent to hearing a story and the form of the story is guided by recipient responses. Both Sacks and Jefferson indicate that some stories can be co-narrated.

Table 3.3.2 shows the difference between understanding that the listener has an impact on the story form and content and believing that the story is co-created by both the teller and the listener. In this thesis I included both columns.

Table 3.3.2 Comparison of analysis using narrative or anecdote

Personal narrative	Anecdotes
Both storyteller and audience contribute to the formation of the story	The story is from the storyteller but how it is presented is influenced by who is listening
In the conversational interviews we were co-creating a story	In the conversational interview interaction we were telling stories in response to each other
The story reveals group identity	The story has something to say about who the storyteller is
The collective story is a written form of passing on of wise counsel extracted, through a reflective process, from the co-created stories in the interviews	The collective story is a reflective written synthesis from stories from people in the same group. As researcher I have control over its form and content. It tells of the collective nursing practice wisdom but also shows the complexity of the context in which this practice occurs.

3.3.4.1 Ricoeur’s *mimesis3* – refiguration

Ricoeur’s (1990) *mimesis3* occurs at the point of time when readers interact with text or listeners hear the story [appropriation]. This interaction can become the catalyst for the reader or listener to reinterpret or refigure their life-world and actions.

Narrative approaches to research currently lack the recognition of ‘evidence-based’ research in terms of usefulness for clinical practice. Yet for a clinical problem that is difficult to objectively measure there is value in dialogue as a way of bringing to light clinical knowledge that would otherwise remain hidden. Remembering that interpretation of what is said occurs on multiple levels.

3.3.4.2 *Dialectics and dialogue*

...to see wisdom as consisting in the ability to sustain a conversation, is to see human beings as generators of new descriptions rather than beings one hopes to be able to describe accurately (Rorty, 1979, p378).

Narrative gives room for the expression of our individual and shared fates, our personal and communal worlds (Richardson, 1990). “The good that communities express and live out is dependent on their cultural traditions, shared narratives, habits, practices, concerns, and experiential wisdom. A community offers the human possibility of dialogue and correction through multiple perspectives and memory of experiential learning from the past. Public moral space is created in community through dialogue and experience lodged in narratives.” (Patricia Benner et al., 1996, pp251-252)

Mishler (1990) considers that dialogue within a community of researchers and practitioners is where research findings are evaluated as to their trustworthiness. If results are relied upon for further research and practice, then the community has found them to be trustworthy. It is through this process that Mishler claims validation as a social construction of knowledge.

“a world constructed in and through our discourse and actions, through praxis. Since social worlds are endlessly being remade as norms and practices change, it is clear that judgements of trustworthiness may change with time, even when addressed to the ‘same’ findings.” (Mishler, 1990, p420).

In terms of the epistemology of this thesis, I believe knowledge is developed through dialogue. Various criticisms of narrative analysis as a way of doing research stem from epistemology. What is knowledge? Does it rely on truth and reality or does knowledge depend on interpretation, developing in an ongoing way along with the language required to communicate it? Rorty (1979) argues that knowledge does not mirror reality, but rather claims that knowledge is pragmatic, not foundational, it allows us to cope and change through a process of edification. Edification takes place in the arena of dialogue rather than experimentation, since it is concerned with understanding rather than ‘finding out’ and development rather than certainty. Dialogue may reach a temporary end point but may not be terminated.

Narrative is a complimentary cognitive mode to the more esteemed logico-scientific way of thinking.

Both are attempts to organise and give meaning to human experience, to explain, to guide problem solving. But the products of these two modes of thought, story, and principle respectively are quite distinct. The product of scientific thinking is a principle or law...testable only by further formal scientific activity. The product of narrative though is context-bound, concrete and testable through ordinary interpersonal checking (J. A. Robinson & Hawpe, 1986, p114).

Nurses are well versed in the use of narrative. In dialogue we can see that meaning is fluid and emergent rather than static. While endeavouring to elucidate this meaning, researchers join in the complexity of narrative through adding their interpretation to that of the storyteller. However, after publication, the consequence of the research is determined by individual reader's interpretations and the addition of this new information within their own nursing practice.

Young (1987) claims that telling personal narratives does something in the social world. Focussing on social use of narratives by particular speech communities, narrative shifts from speech unit to a type of discourse. I think this ties back to the claim that the central agency is in the stories told to me and must be in the story I tell. I am passing on 'wise counsel' extracted from what was told to me. The wisdom is usable to an extent determined by the reader. What was said by the nurses to me and what will be said by me in this thesis must not be tied to the individual that spoke or wrote because people move on. I know that the nurses who spoke with me would have a different story to tell me now, although I suspect the extractable wisdom would still be there because practice in the unit does not move as quickly as individual nurses do. The collective story I write in this thesis is my contribution to dialogue.

Popular versions of history that are different to academic versions can become "*..our story*. It is the story of what *we* did, which shows who *we* are. The group life story includes not just events, but also an account of the group's character, social structure, etc." (Linde, 1986, p198) [her emphasis]. The content of a group life story may include what events have made us what we 'are' or what you must know in order to 'know' us. It has a characteristic of being a discontinuous unit, constantly added to and changed as new stories enter life story, old ones are dropped or revised to maintain coherence. "We may view the group life story as a collective analogy to the individual life story." (Linde, 1986, p198) Oral narrative can substantially contribute to areas of public discourse that are insufficient, for example the experiences of women. However, this can be problematic where the story cannot show the group to be 'good' people who act as they should, for example the Vietnam war (Linde, 1986).

In summary, community narratives help to define the group through maintenance of tradition as well as show the shared wisdom gathered through dialogue of past experiences, seen from multiple perspectives. Individual narratives told by people in similar circumstances within a group can reflect the experience of other group

members. Therefore, narrative is one way of looking at groups/communities and one way that groups/communities look after themselves.

Hegel was a German philosopher whose pupils have become better known than himself, whose philosophical ideas are convoluted and whose language is stilted. He has been attributed to having started the move towards recognition of the subjective as opposed to measuring the objective only. His approach looks at incorporating contradictions in order to find out more about the opposing phenomena. Hegel saw philosophy as a progression and attempted to transcend warring camps. He thought that we are all part of something grander than ourselves (R. C. Solomon & Higgins, 1996).

I first came across Hegel when he was quoted in David Carr's (1991) work – "The I that is We and the We that is I" (Hegel, 1977, p110). David Carr was arguing for narrative analysis to be a method that attended more to the social aspects of a situation than phenomenology which was more interested in the individual experience. I was intrigued by that quote. It reminded me of Kant's concept of the particular showing aspects of the universal.

Hegel's logic is from meta-analysis where he thinks about thinking and does it in a systematic way. Hegel tries to understand a phenomenon by looking at what it is, but more than that he includes in the phenomenon what it is not or at least the relationship of the phenomenon and its contradiction. This becomes a dialectic where understanding is gained through this dialogue between seeming opposites and the process is ongoing. Dialectic, which means controversy, refers to forming knowledge through the juxtaposition of conflicting ideas in dialogue. Hegel wanted to overcome dualism. One idea is presented with a conflicting idea and looking at them together means that a new synthesis of understanding may be formed. *The I that is We and the We that is I* - people seeing themselves equally as they see themselves and as others see them which leads to a synthesis of two perspectives. For Hegel, truth is found in the negativity of movement, instability, contradiction and change (Hegel, 1977; H. Solomon, 1994).

'Sophie's World' (Gaarger, 2007) is a clever story which exemplifies as well as tells the history of philosophical thought through the eras. I read it so that I could understand where Hegel's philosophical position was located within the bigger scheme. What I appreciated about this book was that it was a story that was fabricated within another

story that was created by the actual author – wheels within wheels. ‘Sophie’s World’ speaks to the notion of constitute and constitutive in terms of how we are players within a story but still we make our own story happen. It speaks to temporality in terms of time standing still at the telling of a story but moving on for the players, so it is as much about narrative as it is about philosophy. [But I am not doing a book review here – it was just helpful reading it.]

Hegel viewed truth as subjective and developed through resolving tensions between two positions to a third synthesis position where the two former are not lost. The steps were named: thesis, negation, negation of the negation or thesis, antithesis, synthesis where synthesis will also be contradicted by an antithesis. Hegel’s reasoning was dynamic where the opposite is equally right. In order to know something, what it is not must also be known. The mind goes from one to the other and then both held together in order to move to a creative synthesis. True reality is found in the unity of opposites. Hegel’s example was the concept of ‘being’ to which he applied the opposite of ‘nothing’ and came to a creative synthesis of ‘becoming’ (R. Holmes, 1986; H. Solomon, 1994). One may never arrive at this relational understanding as the dialectic is infinite, that is, there will always be another that is not, so understanding becomes an ongoing journey.

In dialectical philosophy the knower is part of the known because the understanding comes about in the relationship between the two (R. Holmes, 1986). So instead of seeing pain as a phenomenon to be measured through our senses, within this philosophy pain is understood by bringing ourselves, our experiences, and our knowledge, together with what little cues non-responsive patients can bring as well. At the beginning I naturally considered pain as opposite to comfort. Hegel’s dialectic would not move on from pain and comfort as stand alone concepts but would rather see pain incorporating comfort and comfort incorporating pain in terms of understanding so that the most complete picture could be attained.

In terms of narrative, the dialectical philosophy suits the relational aspect of storytelling where there is a teller and an audience and where the narrative itself sits between the two. In terms of our pain care as ICU nurses, looking at what pain in these patients is by saying what it is not, even the discrepancy between what we see and what they possibly experience fits within dialectical philosophy.

Stories are forms of explanation and expression. I have situated this thesis between explanation and expression as distinct pathways to knowledge as within these pages contains a synthesis of both. We tell stories about our lives and we live within stories that are bigger than us. As we apply the concept of a dialectic to stories told and stories lived we are able to come to a place where we can make stories happen.

3.3.5 About internal trustworthiness

Because of their insight and interpretation, narrative researchers are in a position of authority, moral responsibility and privilege (Richardson, 1990), thus, carry a responsibility to show their method of interpretation within the research (Labov & Fanshel, 1977). I have been explicit in revealing my thoughts and decisions during the process of this research as sections 4.1 and 4.2 will show.

Stories function as arguments in which we learn something essentially human by understanding an actual life or community as lived. The narrative inquirer undertakes this mediation from beginning to end and embodies these dimensions as best as he or she can in written narrative (Connelly & Clandinin, 1990, p8).

Robinson and Hawpe (1986) suggest writing criteria for narrative include economy, selectivity and familiarity. When writing empirical narrative, researchers need to discuss selections made, other alternatives and possible limitations critically (Connelly & Clandinin, 1990).

Rather than ensuring reliability and validity, rigour in narrative analysis is determined by authenticity and meaning making (Judy Lumby, 1995), apparency and verisimilitude (Van Maanen, 1988) adequacy and plausibility, “I can see that happening” (Connelly & Clandinin, 1990, p8) and transferability (Guba & Lincoln, 1989). Crites (1986) claims a good narrative has an invitational quality and thus invites the reader to participate in it.

3.3.5.1 Ricoeur’s four dimensions of text

I used Ricoeur’s (1984) concept of four dimensions of text [formal, historical, phenomenological, hermeneutical – refer to Table 3.2.6] to substantiate the integration of narrative methods from the works of the narrative scholars I presented in section 3.2. Ricoeur approached interpretation of text through increasing depth. He started on the surface and progressed to the impact on the reader’s world. Syntax, semantics and pragmatics form the basis of structure, meaning and interactional context in narrative analysis (Mishler, 1986b)

1. Formal

The first layer of textual analysis looks at the system of signs in the linguistic and structural features of the story. Ricoeur asks, *How does the text function?* Semiotics looks at words as signs or symbols [separating] whereas semantics looks at sentences [integrative]. Moving from semantics to syntax is a move from static relation to dynamic relations. Structural analysis is like a learned reading; first the surface reading then an understanding of the structure adds something of its own to the second reading. I used the work of Labov and Waletzky together with Gee to approach the transcripts structurally and linguistically.

Labov relates the formal properties of a narrative to their functions:

(a) referential - “recapitulating past experiences by matching a verbal sequence of clauses to the sequence of events” (“and then what happened?”)(Labov, 1972, pp359-360)

(b) evaluative - “narrative serves an additional function of personal interest determined by a stimulus in the social context in which the narrative occurs” (Labov & Waletzky, 1967, p13) The point or reason for telling a story being told can be found in its evaluative structure; the means by which the speaker conveys how the event structure is to be understood. “...while the event structure purports to tell us what happened to the narrator, the evaluative structure tells us what it means.” (Linde, 1986, p192). If we turn to linguistics, the way the narrator speaks can show us the evaluative structure of the story. Linguistically, evaluation can be expressed as good, bad, unusual, surprising or ‘the way things are these days’ by:

- explicit statements
 - reports by characters in the narrative
 - subtle and inferential -
 - phonological stress
 - voice quality
 - change in register
 - distinctive lexical choice
 - switch from indirect to direct discourse
 - repetition
- (Linde, 1986).

2. Historical

The second level of analysis investigates where the text sits in time in tension with where the reader is in their time. Ricoeur asks, *What does the text speak about?* I used this layer of analysis to find the content of the stories.

3. Phenomenological

The third layer of analysis examines the text-reader relationship or reading experience including textual strategies and reader's mode of reception. Ricoeur asks, *What does the text say to me that is common to the reading experience of others?* It was at this point that that my expressive responding took place, relying on Reason and Hawkins' work with responsive storytelling.

4. Hermeneutical

The final layer of analysis finds tension between autonomy of text and reader's appropriation; similar to Gadamer's 'fusion of horizons'. Ricoeur asks, *How has my world changed because of reading the text?* This level of dialectic is revealed in the thesis in terms of a synthesis of 'knowing' and 'being' to 'voicing'. [The interrelating of these concepts is presented in the interlude and expanded in the synthesis sections 7.2, 7.3 and 7.4.]

3.3.5.2 Researcher's obligations

Like a craft, research is learned by apprenticeship to competent researchers. Kuhn (1970) claims there is "...knowledge embedded in shared exemplars" (p192). Therefore exemplars of how to do different types of research where the method is visible is beneficial. It is important that the warrants for my claims are visible so that other researchers are able to determine the adequacy in how I came about the findings and interpretations in order decide whether they were trustworthy enough to be relied on for their own work (Mishler, 1990). The answer would be yes if the researcher made the work visible by showing data in the form of texts used in the analysis, explaining methods used that transformed text into findings and showing direct linkages between data, findings and interpretation (Mishler, 1990). Recollection, expectation and deliberation are practical concerns which unify parts and make them a whole which becomes thematic (Carr, 1991). The visibility of my work is presented in the method sections 4.1 and 4.2. A summary of my theoretical position is presented in Table 3.3.3.

Table 3.3.3 My theoretical position

us and stories		how meaning is found	
we live within others' stories	constitutive		storyteller's use of chronology
we tell our stories	constitute		thoughts and feelings about events
stories provide a place to interpret life → meaning	→	↗ meaning ↘	attention to context - individual - social - political
stories provide continuity	constitutive		language involved in finding and telling
stories give identity	constitute		storytelling performance
stories are emergent	telling freezes		dialectic

The narrative of this thesis is co-constituted. I co-constituted all the way through the study as audience, as reflective researcher and as collective storyteller. Because audience and storyteller are in co-relationship with each other, in a reflexive dialogue, the meaning of the story can be found through the audience's reflections influencing the storyteller and the storyteller's reflections influencing the audience. Being in co-relationship with my nurse colleagues played out in the interviews in the co-creation of each conversation. Similarly in the thesis I am in reflexive dialogue with the text, contributing my responses to the nurses' stories. Finally, the readers of the thesis as 'audience' can be in reflexive dialogue with my text.

This responsive form of dialogue is the way nurses have conversations about patients. One story from me evokes a story from you that is in response to my story, then I might modify what I say, the theme, and then you pick it up and say, here you are, here is another context of that and another twist on that, someone else picks it up. We stand right inside it and we respond to it and we co-constitute it, take on the general theme and we offer our own individual response. There is this lovely inside/outside movement.

3.3.6 Summary

Being influenced by specific researchers' methods but devising my own way of approach based on my underlying philosophy and my understanding of narrative theory led me to partake of narrative sharing with my colleagues in order to gain new knowledge around our care of unresponsive patients' pain. Stories show how personal values align to cultural values, (Mishler, 1986b) and the narrator's openness or closedness to others. Telling and discussing stories helps to uncover concerns, fears, hopes, conversations and issues. They shed light on contextual, relational and configurational knowledge lived out by the teller in their practice (Patricia Benner et al., 1996)

In order to argue for the methodology of narrative analysis, and especially the methods used in this study, I addressed narrative as a complementary cognitive mode to the more conventionally accepted logico-scientific way of thinking. Ways that narrative can both constitute and be constitutive were discussed. The interplay of language, dialogue and interpretation were also addressed as ways of elucidating the meaning of experiences that are emergent, not static. Narrative thinking is concerned with human meanings, values and concerns as opposed to logical thinking (J. Bruner, 1986). Narrative contains oral truth because it is 'life-like' in contrast to the objective truth of scientific writing (Judy Lumby, 1995). Events and actions are seen to be connected because they are the cause or result of other happenings and are part of a whole story (Polkinghorne, 1988). Therefore, narrative provides researchers a vehicle through which they can grasp the human experience because it is the way humans understand their own lives.

The usefulness of a narrative study is determined after release into community by its use and social impact. Valuing our natural inclination to tell stories and thereby turning to this form of expression and information to gain deeper understandings seems logical. This section covered my philosophical position with regard to narrative, a look at what it means to 'know' and to 'be' within the narrative position I espouse, a perusal of words, structures and meaning found in language used, and the ways stories work to get their message across.

In summary, narrative research allows a look at the whole experience within context and through this, meaning is found by gaining insights of the surrounding social and cultural scene, the identity of the storyteller and their relationship with the audience, and how their story aligns with the dominant stories of the context. Stories that align may have been shaped by the power of the dominant viewpoint and stories that do not align may only be told underground. Reshaping of dominant stories can occur when trust and collaboration, leading to empowerment, allow for emancipatory stories to be told.

I have shown the deeper narrative analysis thinking that is the foundation for this thesis. The method sections 4.1 and 4.2 show how I went about narrative sharing as a researcher and colleague and the basis of decisions made to ensure safety and appropriateness were in place.

Chapter 4: Method

4.1 Data Collection - *welcoming the stories*

A narrative framework affords nursing scholars a special access to the human experience of time, order, and change, and it obligates us to listen to the human impulse to tell tales. (Sandelowski, 1991, p165)

4.1.1 About inviting expression

I had come to believe that wisdom and insight about the care of pain in unresponsive critically ill adults that was not yet available in published literature, would be found within clinical bedside nurses; in that unspoken body of knowledge that comes through 'seeing' and 'doing'. I decided to access this wisdom through gathering words from these nurses and, as seen in the previous chapters, I began a journey to find a way to collect the words and also to grasp an understanding from the words I received. I chose to gather words in narrative form because through stories, nurses' words flow easily in story form. I chose to analyse these words using narrative methods and to present my findings in narrative form as I wanted the thesis to be easily understood by the nursing community. Finding meaning through analysing narrative allowed me to examine complexity in context which was my understanding of how nurses practice. With the belief that shared context and shared language allowed clearer uncovering of insights and understandings, I chose my ICU clinical nursing colleagues as the source of wisdom for this study. I acted ethically and respectfully during the process of gathering and analysing the words from nurses for this study by maintaining awareness of intertwining participant/researcher/colleague relationships, valuing my colleagues and their words given to me, and keeping all that I did visible whilst maintaining confidentiality of participants.

4.1.2 About wanting storied words

As I have previously outlined, nurses frequently tell stories informally to share their day, as a way of debriefing or getting across a point. I believed it was prudent for me to tap into such a well established and effective form of communication in order to obtain the best possible information about my topic to get closest to what happens inside nurses. Stories would give me insights into the complexity that I, as a clinical nurse, knew existed.

4.1.2.1 Rehearsing moved me from 'interview' to 'conversation'

I knew nurses told stories in the tea room, but would they tell stories in an interview with me? I prepared for this study by practicing interviewing with four ex-colleagues, asking them for stories of managing the pain of unresponsive patients in ICU. However, the stories given to me during these practice sessions lacked the situatedness of stories in conversations. For example, I wanted the nurses to have a reason for telling the story, other than to placate me, so that I could see why a story was told and how it fitted in with other stories or with the flow of conversation. These practice sessions produced stories that felt removed and somehow disjointed. I wanted stories to flow naturally and make sense. Polkinghorne (1988) claims that stories are often used by tellers to make a point easier to understand and so the internal meaning of a story is made more known by its location within a conversation. Others claim stories will occur within normal conversation if a person is allowed to talk for long enough (Mishler, 1986a, 1986b; Riessman, 1993). I changed my approach. The interviews for this study then involved more a conversational discussion around my topic, not asking specifically for nurses to tell me stories but letting stories arise as they would in normal conversation. Although, Riessman (1993) found that almost any question can generate a narrative if the investigator approaches the interview as a conversation, I composed an 'interview prompt' [Appendix C] to keep me focused and to provide reminders of the areas I wanted the discussion to cover.

4.1.3 About wanting my colleagues' words

I avoided making the interviewing process of this study a 'meeting between strangers' by talking with my colleagues as friends. Mishler (1986b) claimed that interviewing unfamiliar participants does not provide the necessary basis for adequate interpretation because socially organised contexts of meanings are not known. I chose to interview 10 of my colleagues, nurses who were working clinically in the unit, because I thought we would have shared understandings, both of the unit that we worked in [environment] and of the situation I wanted to talk about [topic]. I thought they would accept me as they knew me and that it would be easy to talk and to get them to tell me stories of nursing situations they were involved in.

From the conception of this project to the actually interviewing of participants, I noticed that some of the people I wanted to talk to had gone to work in other locations. I had changed my work practice from full time to part time on the weekends which affected my status in the unit, and the practices in the unit had changed, e.g. there were a lot

more drug infusions rather than doses. So the study that I envisaged at the start is not the study that unfolded.

4.1.3.1 Using familiarity to gain deeper understandings

Because I had not found answers from the literature, I turned to my ICU nursing colleagues and asked them questions as they seemed to competently and confidently deal with the experience that I was finding difficult. I assumed that choosing to ask my colleagues for information would mean that we understood each other easily because we shared the environment and the distinctive ICU jargon.

Elliot Mishler (1986b) talks about interviewing as a stimulus response type of interaction between two people who are unfamiliar to each other, who do not share assumptions, common knowledge and contextual understandings and do not have reciprocal aims, as well as possibly use language in differing ways. Sharing our social reality at work meant that I thought it would be easy for nurses to talk with me and to tell me stories of nursing situations they were involved in around my topic. I also thought it would be easier for me to make sense of their words in the analysis process. Sharing a common vocabulary would also add to the ease of understanding the words that were given. Further insights from Mishler were discussed previously.

4.1.3.2 Using diversity to gain wider understandings

With an aim to maximise the possible variety in stories given, I chose ten nurses hoping to cover what I thought would be the main areas of diversity in terms of their age, gender, experience; length of time nursing, variety of placements, length of time in ICU, and education; whether they completed their initial nursing qualification in a hospital or university and if they had completed specialty education in ICU. Without any plan to sample, I ended up with eight female nurses and two male nurses which was coincidentally similar to Australian gender ratios in nursing. With the study's purpose to provide insight and deeper understanding of nursing complexities, I was not intending to generate knowledge that would claim direct generalisability to other nurses in other contexts and other times. The aim of choosing participants was for the breadth of their stories. Some nurses I wanted to talk with for this study left the unit to work in other places before I approached them and so I needed to be flexible in my recruiting.

When I looked at diversity amongst the participants from what they said about themselves in the recorded conversation, sometimes they revealed more information about themselves than I was privy to before the conversation and at other times no

further information. I felt a tension between what I knew and what they said during recording. Knowing a lot more about these nurses than appears in the transcriptions left me with a dilemma about just using their words within the thesis or adding my own understanding of them as nurses and people. I chose to just rely on words given to me during the conversations because their consent covered only the words recorded.

4.1.3.3 Introducing the storytellers

I only used the information given to me during the recorded conversations to describe nurses' personal characteristics in order to contextualise their words about pain. Originally I was unsure whether including such information about the participants would jeopardise their privacy but the amount of time elapsed since recording the conversations has been sufficient to quell my concern about the possibility of participant identification. I have changed their names to ensure anonymity.

Leticia had previous experience working on general hospital wards, however, she spent a considerable amount of time working in our unit, during which she completed the ICU nursing course.

Asha described herself as a mature nurse. During her hospital training and before working in ICU, she gained years of general experience as a nurse. Since entering ICU nursing, Asha worked in several units and had specialised education in ICU nursing, during which time she found her clinical teacher was influential on her as a role model. Asha had personal experience of pain, hospitalisation and use of narcotics and has also had a friend in ICU as a patient. Her friend's memories of the experience have influenced Asha's nursing practice.

Robyne learned the topic of pain was an important issue during her time at university. While a student, she also worked as an assistant in nursing and gained experience by caring for elderly patients in pain. As a registered nurse, Robyne was exposed to further emphasis on pain management when working with oncology patients. Robyne had witnessed pain in her father and this had influenced her to be more in tune with patients experiencing pain. Although Robyne was my colleague, she displayed a diffidence which suggested she saw me as the expert in this topic.

Bryce was not inclined to tell me specifics of his background, although he did mention oncology and emergency as areas of previous work and alluded to taking a pain

subject during his formal education, he easily named side effects of opiates and argued for the individuality of pain.

Patrick found caring for patients' pain and comfort had been important from the beginning of his nursing. He attributed most of his learning to role models, and implied he had a low level of experience.

Toni worked in emergency, medical ward, paediatrics and other intensive care units, and considered her present practice to be enhanced by the accumulation of those experiences. In addition to different nursing locations, Toni highlighted her exposure to different cultures as a learning experience. During our conversation, Toni seemed to place less emphasis on formal learning but did mention the influence of the lay media or grapevine. Toni had personally experienced basic ICU procedures. Toni was impressed with hospice nurses who cared for her dying grandmother.

Beth related to me in a concise manner, without much elaboration. She did not share her personal or previous nursing experiences, but preferred to talk about her present nursing practice. Although Beth failed to mention her past nursing experience, I considered her an expert ICU nurse.

Rhea was an experienced nurse who was initially educated in the hospital system. During our conversation, Rhea mentioned several contexts of her work, setting up PCA [Patient Controlled Analgesia], working on a surgical ward, and another ICU. Even though Rhea has had personal experiences of pain, during abdominal surgery, she claimed most of her learning has come from nursing many patients in pain. Although she was undertaking a course, from Rhea's perspective, being taught was an inadequate method of learning about patient's pain. Even with her extensive experience, Rhea would have liked to learn more in varying ICU contexts, because she believed gaining understanding is a continual process.

Taylor was new to nursing and new to ICU nursing. During her time at university, Taylor received both formal learning and experience with patients in pain during clinical placements. She built on this experience when she began to work as a nurse. During our conversation Taylor related to me as though she perceived my status as being above hers, and admitted, at times, being an inexperienced nurse in ICU was frightening.

Petra was brief and to the point and was not prone to embellishment. She did not make me aware of any personal experiences of pain, either in herself or those close to her. Petra attributed her knowledge to a combination of being taught and experience in nursing.

4.1.4 About wanting trustworthy words

Interviewing is different to examining behaviours as it gains access to internal thoughts which cannot be observed directly by the researcher (Van Manen, 1990). People will talk with more ease, eloquence and with less reserve than they will write. Writing forces a reflective attitude that is less immediate than face to face (Minichiello, Aroni, Timewell, & Alexander, 1990).

4.1.4.1 Recording my position before listening to participants

In an effort to gain clarity on my own journey in my thinking on the topic, I recorded a starting point of my ideas and beliefs before I recorded the conversations with my colleagues [Appendix R]. It was as though I was answering the questions I posed to my colleagues during the conversational interviews as well as my own concerns. My intent was to document my thoughts at the point in time before closely examining the thoughts of my colleagues. In some interpretative methods the researcher is required to put aside their position on a topic in order to be free to deal with their research information cleanly (G. Gadamer, 1975; Guba & Lincoln, 1989), however, I positioned myself within this research as a contributor along with my colleagues. It was of interest to see where I started, and what I offered during the interviews and then throughout the analysis and writing of the thesis. I did this in order to be able to compare my thoughts pre-analysis with the developing interpretation of understandings during analysis, checking that I did not overlay my thoughts on those of the participants.

4.1.4.2 Contributing as participant-researcher

In everyday talk, both participants in the conversation play a part in the construction and distribution of narratives. Sometimes a mutually constructed narrative emerges (Langellier, 1989). In the same way the discourse of an interview is jointly constructed by interviewer and respondent. In an interview, responses are not merely answers to questions but also a reflection of the interviewer's assessment of whether the respondent has said enough to serve the purpose at hand and may even reflect a who is controlling direction of the interview (Mishler, 1986b). A narrative analysis researcher attends to what is said by both interviewer and respondent and how they say it. The actual talk of the interview is under scrutiny.

In the recorded conversations for this study, I sought a balance between conversation and interview where both of us contributed to the topic. When I met with my colleagues, each of us brought our thoughts, ideas and experiences to the conversation and together we created an interaction which revealed new thoughts and ideas; we began a new story.

At times during the conversations participants followed a train of thought or raised topics that were not within what I had considered to be the bounds of my research. In the moment of the interview I was aware of controlling my desire to steer nurses back to talking about the information I wanted to hear. Later, during analysis, I appreciated participants' 'off the topic' information and congratulated myself on my restraint.

Although I aimed to gather the nurses' thoughts rather than my own during the conversations, my words were recorded and transcribed alongside theirs and the total package was used together with the pre-interview documentation of my views on the topic. So in essence the conversations were a mutually constructed narrative on my topic. My contribution involved the synthesis at the level of conversation then analysis in collating the whole and forming a collective story, responding with metaphor and poem then finally, in dialogue with the literature, and culminated in writing the thesis.

4.1.4.3 Inviting nurses respectfully to ensure an ethical study

To ensure anonymity I approached each potential participant in private to ask them if they would be willing to be involved in my research. In order to inform their decision as to whether or not to participate, I explained that the aims of the study were to increase our knowledge of how we care for pain in critically ill patients who are unable to communicate with us and to offer suggestions on ways forward in this difficult area of nursing practice. I told them I wished to record, and transcribe, one conversation with them on the topic. In addition, I assured the nurses that their participation in my research was voluntary, promising them anonymity/privacy, reassuring them there would be no negative sequelae for non participation and that if they agreed to be in the study no one else would know they had participated. Only one person declined because she said that she didn't have the answer to my question. Upon agreeing to participate, I arranged a mutually acceptable time and place to meet in comfort without time pressure. The study was approved by the Ethics Committee of the University of Technology, Sydney and the Nursing Research Committee of a metropolitan tertiary hospital. The consent form [Appendix A] was signed at the time of recording the

conversation to create a permanent record of the nurses' willingness to be involved in the study.

4.1.4.4 Time lag between inviting participants and recording conversations

The interval of time between asking each participant to consider being involved in this study and actually meeting with them was less than a week. However, the ten interviews took place over a six month period. Knowing the way nurses talk to each other, I wondered whether nurses might have 'prepared' for their interview by asking others or doing their own research on the topic. During the conversations I did ask participants the source of their ideas on pain and received answers about their formal education, personal experience and role modelling.

4.1.4.5 Locating the place of conversation to ensure comfort

I asked participants to choose the place and time of our conversation to decrease power bias inherent in interviews. Most of the conversations were recorded in the nurses' homes giving them control over the environment and minimising time pressure and interruptions. However, there were interruptions from telephones and housemates and two participants did not want me to intrude into their free time, so following their suggestion, we recorded the conversation at work. I was concerned that this would breach confidentiality and checked with the nurses that if they wanted privacy we should not meet like that, however, these nurses did not want their inclusion kept private. Both of these took place on night duty which was an added pressure as concentration was affected by tiredness, and interruptions were more frequent. Flexibility on my part resulted in the conversations taking place at locations and under the conditions that the participants wanted even though it was not always what I had thought would be comfortable and which would facilitate flow of conversation.

4.1.4.6 Acknowledging limitations due to contrived nature of research conversations

Knowing each other on a work basis as colleagues was an advantage as we shared knowledge of the work context and used a mutually familiar vocabulary. However, knowing each other did not overcome the unusual setting of a recorded conversation. Nevertheless, we did have reciprocal aims because I required 'information' and they obliged by talking of their experience. Experiencing the actual recording sessions made evident the intrusion of the tape recorder and goal of information gathering on what might otherwise have been relaxed and easy conversation, like those which occur in nurses' tea rooms.

The size of the recording device was directly proportional to my discomfort but this reduced over time. The nurses showed no sign of discomfort regarding the equipment at all; they were possibly bemused. I used a large cassette recorder that I plugged into electricity to eliminate battery failure however locating near a power point was an interesting endeavour upon entering an unfamiliar dwelling. As I progressed through these conversations, the need to be able to hear the recording well overtook my embarrassment over the equipment. I used ninety minute audio-tapes but lost a few minutes of talk when the tape needed turning over during some of the longer conversations. Even though I reassured them otherwise, sometimes this interruption was taken by the nurses to mean they had been talking for too long.

4.1.4.7 The interference of my perceived status

Being a colleague and also known as one of the more experienced nurses in the unit and a researcher, I found some of the participants approached me with the attitude that I knew more than they did. Participants not only operate as interactional partners in conversation, but they also enact their social roles in relation to each other (Langellier, 1989). Research interviews have an hierarchical nature. In order to reduce the inequality of power, Elliot Mishler (1986b) recommends viewing the interviewer as a reporter and the respondent as informer. Encouraging nurses to value what they had to say [and I was not the 'expert'], was achieved by explaining that I wanted to find diversity and differing opinions to my own in order to answer my research questions; their view was important to my research.

For example:

...How am I doing so far?

This is just sort of a talk, just a discussion...like I said before, we all do things a bit differently so, and because this has been sort of a problem area for me initially, or it still is, so I wanted to find out different nurses' points of view, that's all. So, that's why I haven't got particular, specific questions, if you tell me your experience of that type, looking after that type of patient and then the things that you think about or the things that you do..

(3:2,26-37)

In addition to my overt contribution to the conversations, I was present as listener and researcher (Mishler, 1986b). During the recorded conversations I did not hesitate in presenting my ideas and answering their questions and thus my thoughts were transcribed along with theirs in each interview.

4.1.4.8 Freezing the fluidity of movement when recording conversations

Over the time of this study changes occurred both in practice and social interaction. These changes impacted on what I had envisaged at the start of the study and resulted in some shifts that were peripheral rather than core to my topic, but nevertheless worthy of mention. For example, the way of delivering opioid analgesic medication moved from predominantly intravenous bolus to continuous infusion. I changed my work practice from full time to part time on the weekends which affected my status in the unit. "Social activity occurs in time and space." (Minichiello et al., 1990, p200) yet recording these conversations freezes a snap shot in time. I chose to record only one conversation with each participant as I was interested in a capture of nursing thinking about practice rather than individual differences or changes over time. Solidifying the fluid activity of nursing practice in a moment of time provides an opportunity to examine it keeping in mind that in the real world movement carries on.

My method of obtaining information was to tape the ten conversations between myself and individual colleagues. I could have triangulated, and thus strengthened the incoming data, by adding participant observation and content analysis of documents (Minichiello et al., 1990; Patton, 1990). However, the intent of triangulation is to produce reliable and valid theories and I was more interested in experience. In congruence with my chosen methodology, I was content with the information provided by the nurses' personal narratives.

4.1.5 About receiving nurses' words

At the commencement of each interview I again reminded my colleagues that their participation was voluntary and they could opt out at any point. Nobody opted out. I went over my area of interest and told them that I was looking for diversity, so that their view was important to my research. Some of the nurses were interested in why I had chosen them and one nurse even suggested other nurses in the unit to whom it would be good to talk.

I asked participants to tell me about issues relating to physical comfort and pain when working with critically ill patients who were incapable of purposive actions. Several nurses needed to clarify exactly which type of patient I was talking about. From there the interviews proceeded to cover those things that the nurse wanted to raise in relation to my topic. I did ask what things had contributed to the nurse's thoughts on my topic and so was told about learning from education, experience and personal

situations the nurse had encountered. The nurses told me what they saw and did and some interspersed anecdotes.

4.1.5.1 Using an interview prompt – the tension between conversation and research

I went into the conversations with the intent of continuing within the already established discourse I shared with my colleagues, although it was still my research and I had determined the topic, so there was a tension within me between allowing the conversation to flow and keeping it on my agenda. Although I had prepared an interview schedule [Appendix C], when looking at the transcripts I saw my approach and way of relating during each conversation was quite naturally and unintentionally directed specifically to that nurse. Mishler (1986b) and Schuman and Presser (1981) argue that each research interview is unique through context, language, interviewer/interviewee relationship, shared assumptions and understandings, and indeed, every question is also unique even if the same words are used. This notion was evident in each of the recorded conversations where my words and the way I presented myself to individual nurses showed the uniqueness of our relationship. I believe that tailoring my approach to participants added to the ease of the interchange and thus allowed nurses to speak more freely.

Hoping to obtain stories in context that were presented naturally rather than forced, I specifically did not ask for stories as such, but commenced a general discussion of the issue of caring for critically ill patients in possible pain when they are unable to tell us. In the preamble I asked my colleagues to think about working with critically ill patients who were incapable of purposive actions, specifically, managing physical comfort and pain and then asked them to talk about any issues this topic might raise for them. Even though I did not overtly ask for stories, I did encourage nurses to tell stories by prompting for examples from practice, telling my own stories in a hope that they would respond with stories of their own, and sometimes asked them to tell me of times that they felt the situation had been managed well or times when it could have been managed better. Nurses' stories occurred in the interviews to exemplify a point that they were making, in response to me asking them for examples of good or bad situations or in response to my stories. Because work and personal stories were often told when I asked about what had contributed to nurses' thoughts on the topic, I wondered what part stories had played in these nurses' learning.

4.1.5.2 Confusion around the word ‘purposive’ for which there was not shared understanding

Although I believed the nurses and I shared understandings and language there was one glaring discrepancy stemming from my struggle to give a name to the particular category of patient in which I was interested. As discussed in the introduction, I arrived at using the term ‘purposive’ and although this accurately describes the specific patients in whom I was interested, it became obvious that we as nurses did not use this word. The word ‘purposive’ was not part of our shared language.

For example

So what, when you mean like, incapable of purposeful actions, do you mean that they’re capable of no actions at all or are they capable of actions that are beyond their control?

They’re capable of moving and such, but if you were doing a neurological assessment on them they wouldn’t purposefully move your hand away. Like it would be nonpurposeful

So you, it could be like a bit of thrashing and something like that

Yeah, because I started off looking at patients that couldn’t communicate, and you go from the level of not being able to verbally communicate to not being able to nonverbally intentionally communicate to you, so I guess its those patients that I personally can’t tell what’s happening with them.

(4:1,28-2,5)

I spent some time at the beginning of the conversations with each nurse to ensure they were clear about the specific type of patient, citing examples or telling them my story which launched this study. I believe each of the transcripts shows that after the initial clarification we shared an understanding of what I meant by ‘non-purposive’.

4.1.5.3 Ending made to conversations by participants to ensure completeness

Aiming for as complete a picture as possible, I wanted to ensure my colleagues had said all that they wanted to before ending each conversation. I attempted to give away control of closing the conversation through the use of pauses and open questions allowing for anything else to be said. However, Minichiello, Aroni et al (1990) suggested that participants may end an interview prematurely and ask how the researcher would know when the text is complete? For my study, I was collecting information within a narrative framework and this allows for the teller to share their story in a manner that is appropriate to the point they are making and their audience. In addition, as a colleague, I was available in the unit and none of the participants

approached me to add to their contribution at any time after the recorded conversation was over.

At the end of the conversation, I thanked them for their time and contribution and because the content of our time together belonged to them as much as to me, offered them a transcription of the interview if they wished, however, this offer was declined by all participants; they were more interested in the research outcome.

At no time during the conversational interviews did any of the nurses become upset or show signs of being uncomfortable with our dialogue, so it was not necessary for me to offer debriefing or referral. Additionally, and thankfully, there were no disclosures of criminal or negligent conduct which would require reporting to the ethics committees, the hospital board or any appropriate governing bodies.

4.1.6 About transcribing - turning talk to text

Although turning conversational interviews into words on a page was only a partial representation of our exchange, it was still an important step towards analysis. Aspects of the conversation that were lost in changing audible sounds to readable text included, the natural flow of speech; rapid changes in pitch, stress, volume, rate, as well as gestures, facial and body movements, which are difficult to describe and record in the lines on a page, but all contribute to the meaning of what is said (Mishler, 1986b). However, the process of transcribing I went through and the notation system I used helped to increase the meaningfulness of my transcripts.

Mishler (1986b) claims strength in a narrative study if transcription of interviews are explicit with a well specified notation system including codes for pauses, talk over, voice tone. Within the transcriptions, I tried to document all utterances and pauses and for this used some of Gail Jefferson's (1978) transcript notation. I chose *Graphite Light Narrow* as a font that I believed reflected speaking rather than writing with *my contribution to the conversation typed in italics*. Notation for unclear talk (...), unfinished sentences (..), and pauses were timed in seconds. I did not have notation for voice quality or speed, neither for non-verbal gestures, but having immersed myself in listening, I was satisfied that the transcripts were as close as I needed to what was said on the tapes. In anticipation of analysis, I left a wide margin at the right hand side to allow for my coding notes, the lines were numbered on each page and the pages were numbered. An example of my transcription is in Appendix D. For ease of reading the quotes within the

text of the thesis have been edited by removing superfluous notation such as 'um' and double words.

The process of turning recorded conversations into words on a page was long and tedious. The transcription process so immersed me in the audible form of the information that I ended up being able to hear each conversation as I read the transcript. This came about by an interesting and time consuming twist. I had originally intended to hand my mother the tapes and receive back the transcripts. Surprisingly, but understandably as she had been a proficient document secretary, my mother began correcting the grammar of the first interview. She left gaps where the medical jargon or any words were not discernible. So we both listened to the tapes and while she typed I deciphered and punctuated and together we came to the conclusion that there are no adequate ways to write some sounds human mouths make and that the utterance "um" deserves a academic paper all of its own. I then edited each transcript on my own, listening to the tape and correcting any discrepancies. The process, although idiosyncratic, was beneficial to this study, especially during analysis as I was able to experience the conversation each time I worked with a transcript.

Transcripts can take on a form of their own so researchers should return to the original recordings to assess their interpretations (Mishler, 1986b). I was happy that the transcripts were as close as I could get to what was said on the tapes. I heeded the warning to keep listening to the tapes. The additional benefit for me in being thoroughly involved in the transcribing process, was that the data was in my head [when I read the words on the page I could hear us talking and see non-verbals as well] and this made analysis easier and probably more accurate.

4.1.7 About using and storing the information confidentially

To ensure there was no accidental loss or misuse of information, I copied each tape before transcribing it. The original tape was stored in a locked filing cabinet at my house and the backup at a different secure location. After transcription, hard copies and backup computer discs accompanied the tapes at each location. All documentation was labelled with number and date of conversational interview but with no link to the nurses' names. To ensure confidentiality, I stored the participants' completed consent forms in my locked filing cabinet away from the tapes, hard copies and backup discs, and without any numbering. I gave pseudonyms to the participants that reflected their gender but were not like any name of people working in the unit at the time.

Access to the tape recordings of conversational interviews and to the transcripts was only available to my supervisors, my mother [as transcriber], and me. However, quotes without any identifying material have been used within my verbal presentations and my thesis, and will be used within any future published papers or presentations arising from this research. My supervisors acted as the immediate point of ethical accountability, reviewing the transcripts and ensuring I adhered to ethical practices both in relation to the participants and subsequently with the recordings and transcripts. Ongoing monitoring of my ethical standard toward the participants and the use of their information was continued by my supervisors throughout the writing of the thesis. Feedback on ethics was given to the University of Technology – Sydney throughout my candidature when required in terms of annual oral student presentations as well as mandatory forms. Likewise, an oral presentation was made to the research symposium at the hospital organised by the hospital research committee. An electronic version of the completed thesis will be made available to the hospital ethics committee.

4.1.8 Summary

Having the privilege of holding words from my colleagues in narrative form obtained in a trustworthy manner meant that I was now ready to search for new insight, understanding and meaning from those words. The next section details the steps and processes of narrative analysis to which I subjected these words.

4.2 Analysis - working the stories

Narrative inquiry is, however, a process of collaboration involving mutual storytelling and restorying as the research process proceeds... mutual construction of the research relationship, a relationship in which both practitioners and researchers feel cared for and have a voice with which to tell their stories...The central task is evident when it is grasped that people are both living their stories in an ongoing experiential text and telling their stories in words as they reflect upon life and explain themselves to others. For the researcher, this is a portion of the complexity of narrative, because a life is also a matter of growth toward an imagined future and, therefore, involves retelling stories and attempts at reliving stories. A person is, at once, engaged in living, telling, retelling, and reliving stories...It is in the telling and retelling that entanglements become acute, for it is here that temporal and social, cultural horizons are set and reset... the process becomes even more complex, for, as researchers, we become part of the process. The two narratives of participant and researcher become, in part, a shared narrative construction and reconstruction through the inquiry (Connelly & Clandinin, 1990, p3-4).

This section exposes how I moved from transcripts of recorded conversations to the expressive forms of metaphor, collective story and poem. The decisions made in this process were based on the thinking presented in the previous section. While the metaphor and poem seemed to emerge of their own accord, most of my effort was spent moulding the collective story.

Within a narrative framework, I am a practitioner trying to understand practice to give back to practice. Whose meaning am I making? I am crafting a story on behalf of the group of which I am a member. I claim ICU nurses recognise the story. I am writing it for them and other nurses as well as members of the multidisciplinary team with whom we work.

Within this study I have both oral and written forms of narrative. The participants told me the original narratives, they did not write them for me. I wrote the metaphor, collective story and poem to convey the meaning of the oral narratives given to me. So I have both the telling at one level then the writing in response to the telling.

My responsive writing assumed a reflexive position (Stahl, 1983). The participants stood as authors of their own practice [Ricoeur's (1986) 3rd notion around human action in mimesis¹]. They narrated their practice to me within the storytelling interaction at interview; nurses were the story tellers and I was the audience. [Although with the concept of co-creation of the story at times we swapped roles when I told a story to the nurses as the audience (Mishler, 1986b).] I then took my responses to each of the nurses' narratives and worked with concepts, words and structure until I came and stood at the heart of it again. Then I told another story but this time the story was in written form as a reflexive response to my experience and understanding of the individual narratives. The way I have undertaken analysis aligns with the reflexive positioning of active listening in story telling (Langellier & Peterson, 2004).

Taking concepts from folklore (Johnson & Mandler, 1980; Mandler, 1984), a story is handed down and passed on; some stories are passed on differently because they are told to another audience in another context in another era or another time, or they are passed down through the same gender or at certain times in people's lives. Similarly, I took wise stories, wise counsel from nurses who were in the culture of practice and I understood the nurses' meanings because I was a member of that community. Then, as a wise counsellor, I constructed the tenets of that practice wisdom for other nurses who did not have that wisdom. The process underpinning the structure of writing the collective story drew on works from folklore. Again this shows an interesting oral to written reflexive movement. There is freedom in individual re-tellings of collective wisdom to fit the telling in with the moment as long as the telling preserves the integrity of the wisdom. Figure 4.2.1 depicts my understanding of the flow of passing on wisdom.



Figure 4.2.1 Passing on wisdom schema

Life-as-lived [what actually happened], life-as-experienced [images, feelings thoughts and meanings held by the person whose life it is] and life-as-told [narrative] are three different entities. Accessing the life-as-told involves interaction between participants, researcher and reader. The act of telling reconstructs the experience (Bruner, 1984; Riessman, 1993; Sandelowski, 1991). Finding meaning in language and behaviour comes through interpreting what is heard and seen. Interpretation occurs at the level of the participant telling, when the investigator listens, then reads and analyses the transcripts, finally the reader interprets when presented with the research report (Riessman, 1993).

4.2.1 About analysing the text

4.2.1.1 Familiarity with nurses' words through reading and listening

According to Ricoeur (1984), writing can separate meaning from the speech event. The written word, in the form of transcripts, can become something other than a representation of the spoken word. A transcript is only a partial representation of speech. It is also a transformation as the natural flow of speech becomes lines on a page. Gone are the rapid changes in pitch, stress, volume, rate as well as the gestures, facial and body movements which are difficult to describe and record. Mishler (1986b) advises researchers to return to the original recordings to assess their interpretations. I listened to each tape as I read the transcript as a whole, so that the bits that were in my head from the transcription process became a whole. Listening to the tapes several times was important because, within analysis, I looked at linguistic meaning in the way participants spoke. Having been intimately involved in the transcription process, I found it easy to 'hear' the participants 'talking' as I read the transcripts of our conversational interviews. I read each transcript often. I noticed that I could also recall the location of our conversation and our non-verbal gestures. This was helpful in understanding the context of the words and demonstrates the importance of researchers' involvement in interviewing and listening to the tapes to check transcribing.

4.2.1.2 Creating individual flow diagrams led to visualising a metaphor

After becoming familiar with the transcripts through reading and listening, I first created temporally ordered flow diagrams for each interview [see Appendix G]. In these flow

diagrams, I outlined how each nurse approached the situation, what they did and what influenced them. Each of these flow diagrams was a one page, hand written, rough pencil outline of that nurse's experience of this situation. Each flow diagram was ironically similar to a decision tree, however, this was not my intention. Across the ten flow diagrams, I was interested to note similarities and differences in emphasis. The point of this exercise was to keep the vertical dimension of each participant in my mind before embarking on the horizontal combining of information.

It was during the process of drawing individual flow diagrams that I visualised nursing within this situation as though working blind or in the dark. The way my colleagues and I approached patients in this situation and what actions we took seemed to fit into the picture I had in my head. I wrote the 'dark room metaphor' [see section 5.1.2] which seemed to convey what we were saying about this situation.

I also wrote a one page summary of each interview [see Appendix Z], similar to Mishler's (1986b) idea of 'core stories'. However, the summaries were used purely for my own tracking of individuals during the process of combining the nurses' narratives into the collective story.

4.2.1.3 Locating and formatting anecdotes

I used Labov and Waletzky's (1967) work to demarcate anecdotes within the text and Gee's (1989a) work to reformat each anecdote into lines and stanzas. I was excited to see anecdotes within my transcripts fall into the Labov/Waletzky structure and follow Gee's claim of speech occurring in short spurts. As suggested by Connelly and Clandinin (1990), these anecdotes were told by the nurses to describe their work or explain their actions and to emphasise a point they were making by giving me a clearer picture of the situation.

4.2.1.4 Analysing anecdotes

Because anecdotes are used to relate events and to make a point, the purpose of analysing anecdotes was to find the theme or point of the story [see Appendix S]. The point of telling the anecdote could be determined by looking at temporal connections between expressive units and how the story corresponded to the real world (Labov, 1982; Polkinghorne, 1988). Meaning could also be found in relating formal structures of a story to their purposes within the story that show the overall advantage of telling the anecdote, that is, to present events from the narrator's point of view with respect to both temporality and significance of those events (Langellier, 1989). The usefulness of

Labov's structural component 'complicating action' lies in that it "reveals the attitude of the narrator toward the narrative by emphasising the relative importance of some narrative units as compared to others" (Labov & Waletzky, 1967, p37), thus justifying the tell-ability of the anecdote and presenting the narrator in the most favourable light possible.

Labov and Waletzky (1967) and later Labov (1972; 1982) described the structure and found meaning through evaluation. Labov's story structure includes:

ABSTRACT - what the story was about

ORIENTATION - time, place, persons

COMPLICATING ACTION - sequence of events

EVALUATION - significance of events / attitude of narrator

RESOLUTION/CODA - what finally happened and return to the present

I used this story structure to locate anecdotes within transcripts and then looked at the evaluative component of each anecdote to find meaning with respect to why the stories were told, how the narrators presented themselves, and what of importance was being said. [For an example of Labov's structural analysis of anecdotes from Interview 2 see Appendix S.]

Turning to linguistics, I found the way narrators speak can help to uncover the evaluative structure of the story. I used the work of Gee (1989a; 1989b; 1991) when attending the sound of anecdotes locating meaning through linguistic analysis. I grouped the nurses' speech by listening to pitch fluctuations and pauses. These phrases contained some of the properties of poetry: such as repetition, parallelism, sound play, juxtaposition, foregrounding, delaying and showing rather than telling. The way the nurses spoke showed their perspective towards the topic and social position towards me. Setting out anecdotes in a line and stanza format allowed the narrative structure and linguistic expression nurses used to become clearer. It was then easier to see the nurses' use of repetition for emphasis, parallelism, and showing rather than telling [see Appendix I]. Listening to the recordings for pitch, pauses and intonation also helped me gain understanding of narrators' intentions.

The ease of applying ways of finding meaning in linguistic use from Gee and story structure from Labov, to the anecdotes I found in the transcript texts, gave me confidence that there was congruence between narrative theory and the words with which I worked.

4.2.1.5 Moving from anecdotes to whole text as narrative

The anecdotes in the interview transcripts were only a portion of all the words the nurses gave me; there was also further information not in the Labov and Waletzky story form. I felt that if I analysed only the anecdotes, a lot of other words with much meaning would have been omitted from my investigation. This would have seemed unfair to the participants who had given of their experience to me, and also a waste of information which could contribute to furthering our knowledge of this difficult nursing situation. At this point I approached each interview transcript as a list of anecdotes between stretches of text that did not fall into the Labov and Waletzky story structure [see Appendix S]. I referred to these stretches of text as 'train of thought'.

First I considered a content analysis on all the 'train of thought' text and a narrative analysis on the anecdotes. I believed that the anecdotes added weight to the point nurses were making, had implicit meaning because we shared the context and nurses would think I would get a clearer picture if they told me about a situation. Maybe anecdotes painted nurses in a way they wanted to be seen, that is actively, not just a person with thoughts and ideas. I thought analysing 'train of thought' content and anecdotes separately would result in themes of similarities and differences with samples of anecdotes to exemplify.

I also attempted to follow the idea of each nurse having told me their 'life-story' about pain care in the interview and as such I endeavoured to portray the sequencing over time; past learning and experiences of pain impacting on nurses' present practice and looking to future pain measurement possibilities. The anecdotes nurses gave as examples were set out in the line and stanza pattern so that I could gain an understanding from nurses' linguistic expression [see Appendix T].

I wondered if the entire conversation could be seen as each nurse's personal narrative or if only the anecdote type stories count as analysable units. I went back to those 'experts' in the field of narrative analysis and again found diversity in approach. Labov and associates (1972; 1982; 1977; 1967) distinguish narrative and non-narrative stretches of text, choosing to analyse only the stories. Agar and Hobbs (1982) believed everything the respondent said was relevant to or had a place in the story. Using three types of coherence to determine how parts of the story fit together, they looked at the whole text. Bell (1988) demarcated boundaries of stories and examined how episodes and stories were linked together. Richardson (1985; 1988; 1990) asked for one episode from life-stories and referred to the text as the women's personal narratives.

It was at this point that I decided to take all the words from the nurses as their personal narrative. I thought the whole text revealed what the nurses believed and was the totality available to me rather than the incidents that have shaped them.

Approaching each interview transcript as the nurse's personal narrative, I attempted to pull out the nurse's words to fit the Labov and Waletzky story structure [see Appendix J].

4.2.1.6 Including myself as contributor

As researchers, we are not scribes but story-livers and tellers, so our stories merge with the participants' stories to create a collaborative story (Connelly & Clandinin, 1990).

Within the conversational interviews, I had contributed my thoughts on the topic; these thoughts were transcribed alongside the nurses' within each transcript. I had intended to be a focuser of the conversation and talk when I needed to in order to stimulate the discussion, but I was also aware that I was the researcher. Keeping in mind that I was a fellow colleague, working in the same difficult situation [which is what prompted this research], and that I had my words transcribed along with theirs, I considered the possibility of using what I had said in the recorded conversations in addition to the nurses' words. Another record of my thoughts was contained within the pre-documentation I had written to answer my own question from my perspective before finding answers from the nurses [see Appendix R]. Again I consulted the literature.

Including the contributions of the researcher is not only congruent with practitioner research, but especially suited to narrative research where a joint story is constructed (Mishler, 1986b). Bourdieu's (1980/1990, p33) opinion is that, "The status of an observer who withdraws from the situation to observe implies an epistemological, but also a social break...leading to an implicit theory of practices that is linked to forgetfulness of the social conditions of scientific activity." Richardson (1988, p204) thinks "Separating the researcher's story from the people's story implies that the researcher's voice is the authoritative one, a voice that stands *above* the text...Further, by objectifying ourselves out of existence, we void our own experiences. We separate our humanity from our work." [original emphasis]. Harre (1985) suggests we as researchers accept responsibility for the creation of knowledge by engaging with others. We can come to a different understanding of what knowledge is by offering, through talk, our thoughts on the topic and research actions to others as open sets of

possibilities and listening to their responses. "...as researchers, we become part of the process. The two narratives of participant and researcher become, in part, a shared narrative construction and reconstruction through the inquiry." (Connelly & Clandinin, 1990, p4) Reinharz (1984, p354) described the process as a looking outward and inward at the same time when "the researcher is not elite or aloof but becomes the subject of his [sic] own investigations."

I was convinced that it was reasonable to include my recorded words. Further, I believed that if I did not include myself in the research data, it would diminish the fact that the research had come from my practice. Because each whole transcript text was a co-constructed narrative of our specific nursing response, I expanded past just anecdotes to include an examination of my words as researcher and participant in addition to all that my colleagues said. So I used all the words transcribed, both mine and the nurses', as well as the document I had written of my thoughts on the topic before commencing the process of analysis. I did not add further thoughts of my own to this data as time went on, rather only those that were recorded and frozen in time alongside those of my colleagues. However, my contribution continued in the form of analysis through interpretation of all the narratives.

Because I was a practitioner colleague as well as researcher, instead of trying to maintain distance from the participants and split myself as researcher and responsible participant, I tried to be a situated, construing and self-critical, reflective practitioner within the study (Usher & Bryant, 1989).

4.2.1.7 Coding for content and meaning

Elliot Mishler (1986b) refers to traditional interview analysis where answers to interview questions are taken away from both the context within the interview and from the life setting of the respondent then the researcher reintroduces these contexts implicitly or ad hoc during coding. Narrative analysis is not so linear, but rather moves between the original data and the emerging meaning similar to Gadamer's (1975) hermeneutic circle. A movement back and forth between the whole narrative and segments was used to find meaning. Throughout the analysis, meaning was found when I kept the context in mind, saw stories in terms of parts integrating into wholes and the whole in terms of the parts and contributed my perspective and point of view (Gregory & Longman, 1992; Kockelmans, 1975; Tappan, 1990). As in Gadamer's (1975) 'fusion of horizons', I reflected and allowed what I have read to contact my

experience and change me. I was acting as ‘the wise woman’, discerning and engaging myself together with the text.

To gain understanding and meaning I ‘over read’ the transcripts with Ricoeur’s (1984) questions in mind; how does the text function and what does the text speak about? I looked at the transcripts remembering Ricoeur’s four dimensions of text [formal, historical, phenomenological and hermeneutical – refer to section 3.2], beginning with surface structures and then progressed to deeper embedded meaning. I coded by asking questions of the text, looking outward and inward at the same time using Mishler’s (1986b) questions:

1. What was being said? [summary of content]
2. How did the speaker feel about what was being said? [evaluation]
3. What was the point of what was being said? [how explanatory systems and socio-cultural values were expressed and how the participant’s image of self was portrayed]
4. How did the way the words were expressed affect their functional significance? [temporal orderings, connections and structural form]
5. How did elements of our conversational interview affect what was said? [the context, me as questioner, listener and co-participant in the discourse].

I open-coded all of the interviews by writing answers to the above questions in the wide right-hand side margin. If any questions arose in my mind, I recorded them as interpretive notes separately [see Appendix V]. Putting together the codes from all the interviews into one logical flow [see Appendix Q], I combined these codes to create a collective [paper/scissors/glue] flow diagram of how these nurses approached the situation, what they did and what influenced them. I used this flow diagram as a writing plan to create a collective story. The individual anecdotes were useful in highlighting specific aspects of the collective story.

Because I worked within the complexity of the context and shared understandings with my participant colleagues, there were many occasions where my experience as a clinician enriched interpretation. I noted the consistency between teller and audience in both directions as colleagues, and because of our shared context and language. After independently coding the first three interviews, one supervisor and I compared our interpretations and I found that I needed to explain to her the understandings I shared with my colleagues. This supported my claim of the advantage of clinical understanding in the field.

During analysis in narrative research, the researcher is involved in a process of 'expansion' where all the available information that would help in understanding the utterance in question is brought into the analysis. This includes making explicit references to other material, presumed shared knowledge between participants, factual knowledge and general knowledge of the world. In the end interpretation of meaning relies on shared intuitive cultural understandings (Labov & Fanshel, 1977; Mishler, 1986b).

4.2.2 About structuring the findings

Putting together all the flow diagrams into a story created by me with information from the group meant that as a collective we might know that we were not alone in our experience and additionally be more easily heard by other members of the multidisciplinary team.

4.2.2.1 Writing the collective story in Labov and Waletzky's structure

I developed the codes whilst simultaneously analysing anecdotes. Richardson's (1985; 1988; 1990) work gave guidance on how to present my findings. Richardson wrote her collective story as a chronological subsection of life-story published in a book. Her story was interspersed with interpretation and analysis. My findings were not so easy to arrange into a temporally linear story. I felt I needed to structure the collective story according to some accepted story structure.

The Labov and Waletzky story structure that I had used to delineate anecdotes seemed the logical format in which to present the collective story. I followed Labov's story structure for the collective flow diagram. After placing all the codes in appropriate places, I refined the collective flow diagram until it could comfortably fit on the computer [see Appendix Q]. I began by pulling quotes from the transcripts to explain each code [see Appendix P]. I did not get very far with this exercise. Next I attempted, using one conversation transcript, to write under Labov's headings [see Appendix J]. This also did not work. I felt I needed to structure the collective story according to some accepted story structure, but I found the 'complicating action' difficult to organise in a temporally linear fashion. Although I tried to frame the 'complicating action' in the sequential logic of assessment then management, it was much more complex and there were other issues that needed connecting to this core.

ABSTRACT - it was a difficult nursing situation.

ORIENTATION - patients, unit and staff

COMPLICATING ACTION - assessment then management (however, there were other parts of the story that needed connecting to this core. These were arranged on the paper/scissors/glue flow diagram, showing their impact with the use of many arrows)

EVALUATION - paradox of maximising comfort while saving life in ICU

RESOLUTION - uncertainty

4.2.2.2 Structuring the collective story under Johnson and Mandler's episodic framework

The Johnson and Mandler (1980) folk tale format, which had been shown to facilitate recall and was able to accommodate complexity through its episodic framework, provided a logical alternative story structure. Each episode occurs within a SETTING and consists of a BEGINNING EVENT, followed by a DEVELOPMENT where the protagonist reacts, plans and acts, which leads to an OUTCOME which can either be the BEGINNING EVENT of the next episode or the FINAL EVENT. Using quotes from the transcripts so that the nurses could speak for themselves as much as possible, I wrote the first draft of the collective story. However, this version of the story was extremely large [see Appendix W].

4.2.2.3 Condensing the collective story

Judging that the collective story needed to be presented in a more concise way, which was consistent with Robinson and Hawpe's (1986) suggested writing criteria for narrative being economy, selectivity and familiarity, and being guided by the thought that whole transcripts cannot be published and the researcher needs to sort, organise and analyse in order to transform the transcripts into the research findings, I analysed and chose what I felt was important to retain and what to discard or summarise.

I started with many direct quotes because I wanted the nurses to speak for themselves as much as possible and because I did not want to paraphrase what they said. I made the collective story manageable by eliminating the quotes and reducing it to one episode. Therefore I did not follow exactly how Richardson did her work because she wrote a book for her collective story and my work is in the form of a thesis with the collective story just one section.

This reduction process was accomplished over many drafts. First I made it less like a chart and more like true fiction where this story did not actually happen as written but

was based on actual happenings. I made the story take place on one particular shift where all the nurses looked after non-purposive patients and told the happenings of that shift. Because it was generally felt that true fiction would not be acceptable within a thesis, I then eliminated the fiction, put headings through the story, in an attempt to show the story structure, added my own contributions, cleaned up the quotes by removing the “um’s” and repeats, so that they were easy to read. Writing the story outline [see Appendix F] helped me to write the story in one episode and it was within this version that I wrote more of my analytical thoughts. In the final version, condensing has merged the individuality and quotes from my colleagues words.

At the end of the condensing process I had synthesised a one episode collective story [see Appendix E] which was honed down in size to the collective story presented in the findings. In order to keep track of such large accounts, I wrote outlines for the collective stories [see Appendix F]. Although I felt the story presented well in one episode, I would have been happier for my colleagues to speak more for themselves. However, my colleagues’ words are used to explain points within the discussion.

4.2.2.4 Reception of the collective story

Richardson (1990, p129) spells out her criteria for good research using this method. "Although the narrative is about a category of people, the individual response to the well-told collective story is, 'That's *my* story. I am not alone.'" [original emphasis]. I have received positive responses to this research from two groups of intensive care nurses. I received the ‘phenomenological nod’ [the concept (Van Manen, 1990) attributed to Buytendijk 1962 (Van Manen, 1990)] when I first developed and shared the collective story with colleagues at a research symposium within my hospital. At this symposium there was a forum of nurses from throughout the hospital campus, including several intensive care nurses, three being participants of this study. After my presentation, I was given verbal feedback from several people who worked with me, saying, “That’s exactly how it is.” A nurse from the intensive care unit of the private hospital on campus said that she noticed nods and smiles throughout the audience as I was talking. She asked me to repeat the presentation for the intensive care nurses at the private hospital. The response from the private ICU nurses was, “Well, it’s the same up here, you know.” These responses were not openly invited, but were initiated by the listeners.

Subsequently I made several attempts to revisit the collective story with the idea of making it more exciting. Combining all the information into one shift, I wrote the story of

a shift where all the participants were rostered on and were all allocated to care for unresponsive patients: for example one was dying, another was neurologically injured and another had multi-system failure. The story involved what happened during the shift and then the content of the brainstorming session during the allotted afternoon tutorial time [see Appendix U].

Using the idea of the story of one being more powerful than the story of many (Beiner, 1982), I then attempted to write fiction from the perspective of one nurse but based on the concepts in the collective story. The nursing character in the fiction, 'Esrnun' [nurse spelt backwards], was a changeable character representing different nurses in different segments of my fiction. I wanted Esrnun to stand for either gender and varying levels of experience and learning; the generic 'nurse'. I wrote snapshots of moments in ICU with different types of unresponsive patients. Although I did not feel 'inspired', I wrote this fiction freely from within myself; from my experience, what I had observed, what I had read and what the nurses I spoke to told me rather than deliberating over written information from the study. I believed I was writing 'true' fiction as a plausible combination of actual events with what would be possible. The result was several unfinished works [see Appendix K]. This turned out to be blind alley as I did not complete the fiction as I was content that the version of the collective story in this thesis fulfilled the aim of representing a collection of the participants' stories together with mine. Although the collective story was deemed to be dull, I was content that the expressive forms of metaphor and poem were more interesting.

4.2.2.5 Exemplary nursing stories

I chose one anecdote that each nurse told during the recorded conversation [see Appendix N] that I thought typified them to showcase their particular practice and their main difficulty or insight. [There are only nine as one nurse did not relate an anecdote.]

Leticia - the 'cure versus comfort' scenario is difficult and doctors discredit nurses' assessment

Asha – it is easy for nurses to be less connected with patients who cannot speak and in response nurses just 'do their job'.

Robyne - dying is painful, death is the ultimate 'comfort'

Bryce - even though nurses can only go on their previous experience of other similar awake patients, unresponsive patients are individual

Patrick - comfort can be something new and unexpected, like a non-routine body position

Toni - a non-moving patient is comfortable, although that is not always the case

Rhea - for there to be comfort, mental anguish needs to be removed, narcotics can achieve this

Taylor - relatives expect nurses to know what the patient is experiencing

Petra – nurses can get medication ordered from doctors if they approach the right doctor

From these issues, I might have written a ‘what is comfort?’ story using different individual nurses’ voices. Other stories might have been ‘what is pain?’ or ‘what is expected of nurses?’ Alternatively, the metaphor could have been the collective story and then each chapter could have had a heading story elaborating on the aspect under discussion. However, I digress. I chose to stay focussed.

4.2.3 About responding expressively

Reason and Hawkins (1988) innovative work with telling stories and responding with further storytelling to elicit deeper meanings provided another perspective on my creations of metaphor, collective story and poem. Reason and Hawkins analysed stories by wandering around them, looking at them from different perspectives, seeing stories within stories, or the drama of the storyteller’s life. Then Reason and Hawkins wandered inside the story by reliving it through playing characters or personifying and giving voice to objects within the story. This led to responding to the story with a story or another expressive mode, like poetry or myth. The responses were classified into four types; replies, echoes, re-creations, and reflections.

The forms of expression that I wrote in response to participants’ words resulted from a deep and prolonged wander around and inside nurses’ personal narratives and anecdotes. My personal expressive response at the beginning of the analytical process was the conjuring of a metaphorical image and my writing of a metaphorical description. The collective story evolved slowly through much deliberation with the text.

The poem emerged from contemplating the value of metaphors. I could classify each expressive piece according to Reason and Hawkins’ types:

1. Metaphor – reply [‘my reaction to your story’]
2. Collective Story – re-creation [‘your story recreated by me’]
3. Poem – re-creation [‘your story recreated by me’]
4. Thesis – reflection [‘my story about your story’]

4.2.3.1 *Expressive inquiry*

Expression as an alternative path to knowledge provides us with appreciation of ‘words’ and ‘form’ in and of themselves as ways of bringing us to ‘know’. Reason and Hawkins describe a path of research using forms of expression as equal to that of the path of explanation [see the methodology section]. As I analysed the transcripts, visual imagery came to me and I wrote a metaphor. After the collective story was written I gathered the nurses’ metaphors that were scattered throughout the conversations and arranged them into a poem. I personally found the metaphor and poem powerful and attention holding. Both the metaphor and the poem were written in artistic fonts which added to the overall expressive impact.

Based on the Reason and Hawkins diagram of the expressive and explanatory paths of inquiry [see Figure 3.1.1], I considered how my study might align with the either of these paths. Clearly there were expressive forms but my thesis sits between expression and explanation.

Experience - nurses’ experience happens when they are confronted with unresponsive critically ill patients and when they consider those patients’ pain.

Record/Data/Accounts - an account of the nurses’ experience was recorded during taped conversations between myself and ten of my nursing colleagues.

Themes/Metaphor - when reading through transcripts and coding, I felt themes were not comprehensive enough or did not show the whole picture. I tried forming flow diagrams for each conversation and this prompted me to write the “dark room metaphor”, which may actually be a combination of the metaphor of darkness and a mythical story. I looked at the transcripts to see what metaphors nurses used and arranged them into a poem.

Case study/Story - I was enticed by the nurses’ anecdotes. I looked at one anecdote [Haematemesis and malaena] to see if it reflected the themes but again it did not cover all that I had found.

Typology/Saga - I combined all the flow diagrams and themes into a collective story.

Mythical Story - The dark room story

4.2.3.2 *Nurses’ metaphors in poetry*

Another expressive moment during analysis occurred when I used my colleagues’ metaphors to create a powerful and quite moving poem [see section 5.3.2]. After the emergence of my metaphor in the form of a ‘dark room’ and realising how that metaphor had helped to deepen my thinking, I turned to the nurses words to find the metaphors they alluded to in the interview transcripts. Later I listed nurses’ metaphors

from the transcripts under categories of what they were describing [see Appendix H]. These words from nurses became the basis of the original poem [see Appendix X]. However, at the time I failed to reference where phrases were located within transcripts. Still later I went back to find nurses' exact words and documented where each phrase was from [see Appendix Y]. It was obvious that the original poem did not use exact words and so I went through the poem and changed it to exact words given by nurses in the recorded conversations. I also experimented with the order of the poem by swapping verses one and two. However this format did not last. With the second verse located at the beginning, the patients are introduced first whereas I am really talking about nurses. Additionally, with that adjustment of format the poem portrays patients 'doing' actions whereas my topic is about patients lying there for whom there is not much indication. With the verses arranged as they originally were, the poem reads like the whole pain picture might be missed and yet when nurses really 'see' we can see the possible torture. The poem as it stands includes a few more metaphorical phrases that I found while searching for the correct source of the phrases in the original version.

4.2.3.3 *The freezing of stories through writing*

In spite of the frozen nature of our story in time, both in the telling during the recorded conversations and in the writing when I created the collective story, freezing does not reduce its impact but invites us to continue expressing and explaining ourselves in the form of storytelling in an ongoing way. The expressive responses in this study show fluidity; how one story can elicit another and so the dialogue extends. The writing is frozen but the reader's response to the writing is fluid as the story is retold, relived or created over again.

4.2.4 Ensuring trustworthiness

Throughout this thesis I have documented my decisions and my reasons so there was congruence between what I intended, what I did, and what I found in this study. I will outline briefly here the steps that I believe show the intrinsic trustworthiness of this study:

1. Congruence between narrative theory and the data of this study
 - (a) naturally occurring 'Labov/Waletzky' structured anecdotes within conversational interviews
 - (b) the above anecdotes also showed the form and function of Gee's linguistic work
 - (c) study and story frozen in time

2. My use of self as researcher
 - (a) I was the interactional partner in the conversational interviews
 - (b) preamble of conversational interviews tailored to context and participant
 - (c) my shared understanding with participants - shown especially during coding when I needed to explain participants' words to my supervisor
 - (d) explanation of confusion caused by using 'purposive'; a word that was not part of our shared language
3. My use of self as contributor
 - (a) I documented my thoughts on the topic before commencing analysis
 - (b) my thoughts that I used as 'data' were frozen in time alongside those of the participants - both in the transcripts and the pre-documentation of my views on the topic
 - (c) my interpretations of participants' words could be checked as to whether I was swayed by what I thought before I looked at the nurses' words. I could determine if I was overlaying my thoughts by comparing my interpretations to my pre-analysis document.
4. My attention to detail
 - (a) explicit transcriptions
 - (b) reading and listening
 - (c) vertical dimension analysis - individual flowcharts
 - (d) horizontal dimension of analysis – coding
 - (e) basing the form of the collective story on a proven structure - for ease of comprehension and recall
5. Member checking
 - (a) returning the collective story to two groups of intensive care nurses
 - (b) receiving positive feedback that the collective story resonated with their experience

In addition to the intrinsic trustworthiness of research as shown through the audit trail made explicit within the thesis, Mishler (1990) considers that research findings are evaluated as to their trustworthiness when, within a community of researchers and practitioners, results are relied upon for further research and practice. Consequently, the worth of this research will also be determined when the findings are used in clinical practice and discussed within the dialogue of the nursing community.

4.2.4.1 Impact of myself as researcher on the research process

The experience of doing research is a factor in the constitution of knowledge. As I have exposed within this thesis, pragmatics played a role in decisions on methodology and method. Usher and Bryant (1989, p151) suggest that the researcher is “...a problem-solving practitioner, not only in relation to the analytical aspects of a chosen substantive topic of inquiry, but also in relation to those cultural, economic, and political problems that are entailed by that choice.” Therefore, I have been explicit in my description of the research process and how I have impacted on this study, in addition to inclusion of my thoughts on the topic and contributions within the conversations. I examined myself as the researcher and co-participant practitioner.

Introspection, in terms of Mead’s (1962) characteristics of self, guided my systematic review of my conduct as researcher [see Table 4.2.1]. Each of these points has been discussed within the thesis.

Table 4.2.1 Mead’s points of introspection

Reflexive (can be subject and object)	I reflected on my practice as a nurse, on my method of procuring information, on my analysis techniques, on my thinking and on how this work has been received in the past or may be received in the future
Relational (in social situations)	how I related to my colleagues at work, the participants during the research, my supervisors and other people in my personal network all impacted on the ‘doing’ of the research
Communicative (engaged in symbolic exchanges)	the communication within the conversations, when writing, when presenting verbally are all influenced by myself as researcher
Structure (through role taking and game playing)	my various roles as nurse, researcher, colleague, leader [when in-charge], student, mother, daughter and sister added to the depth of personal knowledge but took from the resources available to complete this work

Further guidance for reflective checking came from Usher and Bryant (1989) who specify areas to be addressed by the researcher when undertaking a socially situated inquiry. [See Table 4.2.2]

Table 4.2.2 Usher & Bryant's reflective checking

Subjects	defined as ten of my ICU nursing colleagues. The procedural possibilities or obligations are covered in the previous section
Auspices or sponsors	the 'formal' legitimacy applied to research is that successful completion is awarded a higher degree
Audiences	The expectation is that processes and outcomes will be reported in the thesis and to the nursing community in the form of conference presentations and journal articles. There have been several verbal presentations but as yet no published written work.
Practicalities	limits of time by my other responsibilities but time given to me in terms of hospital research unit secondment and university thesis completion grant. Resources made available at supervisor's research unit, university graduate centre and hospital medical library.
Ethics	the university and hospital have issued ethical clearance. Responsible to participants' confidentiality and privacy. Responsible to participants to complete study. Responsible to nursing community to communicate findings. Responsible to myself for maintaining personal integrity, diligence and persistence.
Purposes	to show complexity in caring for unresponsive ICU patients' pain and to open up the topic for discussion amongst nurses.

Richardson (1990) raises the issue of the researcher having authority and privilege to tell others' collective story together with the researcher's insight and interpretation. Telling a collective story makes possible collective identity and collective solutions. A collective story can alter the direction of our lives. My research presented nurses as human actors within the unit/hospital/culture, showed their actions as well as their goals and impediments and exposed the surrounding complexity. I created text by bringing together others' meanings discerned by me, and my own meanings, for others to read. This study is a contemplation and reflection on nurses' actions. Will nurses contemplate and reflect on the message of this study and change their actions?

A narrative framework affords nursing scholars a special access to the human experience of time, order, and change, and it obligates us to listen to the human impulse to tell tales (Sandelowski, 1991, p165).

4.2.5 Summary

The dichotomy of distance and intimacy in story telling allows narrators the space to reflect on their actions, individually interpret them, then connect with common experience (Churchill & Churchill, 1992). Because of this commonality, listeners, or readers, are able to recognise their stories in the stories of the narrators (Polkinghorne, 1988). I hope that nurses will connect with the story and recognise aspects of that story as their own. The collective story can enable individuals within a collective group to identify with each other's experience and thus be empowered (Richardson, 1990). When nurses realise from reading the work of this study that there are others dealing with the same difficulties, what might change for them in terms of their own person, their interpersonal relationships, their interaction with the environment of ICU or the hospital?

I want to show possible ways forward to a place where nurses might stand, intrapersonally, interpersonally, and contextually, in a climate that would be conducive for them to provide care that results in optimal comfort for these patients.

The following three sections, present the expressive findings of this study: section 5.1 the 'dark room metaphor', section 5.2 our collective story and section 5.3 the poem of nurses' metaphors. Following is section 5.4 which presents the explanatory findings of this study in terms of the tensions between and interweaving amongst concepts.

Chapter 5: Findings

5.1 Metaphor - exposing the dark

As I worked with the transcripts a visualisation of a dark room came to me. Similar to the concept from Reason and Hawkins' (1988) study, where expressive responding was encouraged between participants, I responded to the words from my colleagues with a metaphor. Coming from me, in response to participants, makes this metaphor a *reply* story representative of my way of viewing this difficult nursing situation. Teasing apart the concepts contained in my metaphor revealed stories and counter-stories of the areas of tension in which we work.

5.1.1 About metaphors

A metaphor is a figure of speech where unlikely words are applied to something to which they are not normally applied in order to imply a resemblance. Metaphors create unexpected comparisons that give insight into the topic. (Kangas, Warren, & Byrne, 1998)

The word metaphor comes from the Greek word *metaphora*: a combination of *meta*, meaning 'over', and *pherein*, 'to carry' (Hawkes, 1972). I. A. Richards (1936) coined the terms 'tenor' to mean the topic of the metaphor and 'vehicle' being the new concept. Ricoeur borrows from Aristotle: *phora*, change, *epiphora*, a kind of displacement (Ricoeur, 1978). Metaphors create new meaning.

Aristotle regarded the use of metaphor to signify deep thinking and the creation of new knowledge. He taught that "the greatest thing by far is to be a master of metaphor [literally: to be metaphorical, to *metaphorikon einaĩ*]. It is the one thing that cannot be learnt from others; and it is also a sign of genius [*euphuias*], since a good metaphor [literally: to metaphorise well, *eu metapherein*] implies an intuitive perception of the similarity [*to to homoion theorein*] in dissimilars" (Poetics 1459 a 3-8) (Ricoeur, 1978, p23).

Ricoeur (1978) says that fresh metaphors [not over-worked and commonplace ones] reveal a new way of seeing the original concept. Metaphors have genuine cognitive import in their own right and creatively transform language. By rearranging language, metaphors have an impact on epistemology. Ways of looking at something and concepts are also rearranged. By providing a re-description of reality, metaphors have

an impact on ontology. Change and novelty opens up possibilities and reveals the essence of the topic. New ways of being can be reached. Lakoff and Johnson (1980) purport that through metaphor we experience one thing in terms of another. Metaphors can have a structuring role in the way we speak, think, experience and act.

My metaphor involved picturing nursing in a dark locked room. Dark because there were so many unknowns; nurses rely on gut feelings and putting themselves in the place of patients [guessing]. Locked because the doctors control analgesia and there are other constraints. Some things shed hints of light into the room: memories of ICU experience as a patient, the nurses' previous experiences of pain, either themselves or seeing it on others. I chose to display the metaphor in a darker and bolder font to depict how this situation feels.

5.1.2 The dark room metaphor

Imagine a dark room; the environment of limited knowledge that surrounded this nursing situation. We entered into this room in order to attend to the pain and comfort needs of non-purposive patients. We could see only the silhouette of the patient in the bed. However, just like a blind person can see with their other senses, our inner eyes saw much more than just the outline of these patients. We dispensed care from our satchels of personal experience and knowledge, containing insights and items of care which may have been beneficial to these patients. Previously, and as we continued to nurse, our satchels were filled with experiences, both personal and nursing, with a bit of the memories of theoretical learning. The nursing profession told us to dispense this care impartially and conscientiously. However, we found that some of the shapes of these patients' silhouettes, in addition to what our inner eyes saw and things the relatives might have said to fill in the picture, would influence us to dig deeper into our satchels. Sometimes doctors removed from our satchels some of the items of care considered to be more effective. We then had to cope with less care options and probable pain for these patients. We could not tell if the care given to these patients had made any difference because it was so dark. The available light of scientific knowledge had not yet penetrated this room. The only source of light to this room was through a crack around the door which came from those patients who had managed to make it out of the room and had been able to tell us what they remembered experiencing while in there. We rathered these patients lost those memories.

I used the wording of concepts from the metaphor as a way to organise my thoughts in the explanatory findings. The following pages cover the questions I asked around the concepts in the metaphor. This questioning process helped to develop my thinking so as to delineate the issues I found important to discuss.

5.1.2.1 *Is it a room?*

The whole process of entering into a confined area of doors/locking related to the management of work in the constraints of time and tasks by nurses whereas doctors were much more geared to a sequence/trajectory/progress/pathway. Tension between nurses and doctors was exemplified by the use of the pain and sedation chart when the complexity nurses saw could not be represented by the simplicity of documenting a number.

5.1.2.2 *Is it dark? [uncertainty]*

Knowledge has been equated with light but where does the knowledge come from? Is not understanding also light?

5.1.2.3 *Do we go in or not? [connection]*

Going in would not be considered by doctors if for them there isn't a room. We might not go if we are coping by distancing or ignoring [looking for pain cues is not important, pain is covered, there is not enough time or signs of pain have to be 'in your face' before it is treatable]. Some nurses cope with uncertainty by investigating too much. We may stay in the room too long to the detriment of ourselves and the speed of other necessities.

5.1.2.4 *What do we see? [best guess]*

Do we have time to 'see'? Have we looked here before? The outline may be filled in different ways. The mind's eye makes up its own picture based on what we believe, know or have experienced. Using case knowledge; lying still could mean comfortable or paralysed, also narcotic can relieve pain and cause nausea. Using patient knowledge; this patient has specific condition which could be like others. Using person knowledge; this person is unknown but the relatives may help. We know this is an individual but we generalise to fill in the picture. We may not admit that there is only an outline available if our mind's eye picture is strong and we have a strong need to believe what we imagine in order to cope. We 'do' directly in response to 'seeing' so the tensions around 'seeing' different pictures means we want to 'do' different things. We have to cope when our mind makes up a picture of pain by 'doing' what we can and

hoping the patient won't remember. How important is the actual experience at the time? How much pain is acceptable? We can be numb to routines.

5.1.2.5 *Getting things out of our satchel [constraints]*

Do we have a satchel? What is in our satchel? How did the contents get there? Saying that we have a repertoire of options on which to draw to treat pain is a concrete view compared to others who talk about the therapeutic use of self. However we conceptualise what we are, we have resources. The tension around resources is power to use them. We may be prevented from doing what we think is most effective or we may not have enough time or we may be belittled. What is the order of importance or effectiveness of the options in our satchel? [Potential for narcotic addiction, what can massage or minimising talk do?] What is the basis of justice in allocating who gets what care. The motivation for 'doing' or not 'doing' may be based on what others might think of us - versus - what we want for ourselves- versus - our rapport with the patient or relatives- versus - our beliefs about being busy - versus - disturbing the patient. What is the impact of our changeableness?

5.1.2.6 *Developing the concept of 'seeing' in the darkness*

The metaphor of darkness shows what it is like to not have an objective measure of pain experience in unresponsive patients. Not knowing how well we are performing as nurses or the outcome of our care for patients leads to nurses experiencing anxiety because pain experience and the possible sequelae are unknown. Pain care for unresponsive patients does not seem to be 'evidence based'. At best this pain care may be a guess and at worst it may be ignored. Not basing practice on evidence leads to variations and inability to set a consistent standard. Patients may be receiving poor care but how do we define poor care? What is the base acceptable practice in pain management? To what do we link possible pain experiences? [medical conditions, gender or tissue damage?] What is the basis of this linkage? How do we learn to link? What is the outcome for patients when care is variable? Are there some consistencies for some pathophysiologies? In the absence of objective measures what type of research needs to be done to determine minimum standards? Maybe information from expert practice or the collective wisdom of practitioners would be helpful. How does individuality get factored in?

Assessment in nursing involves senses; sight, touch, hearing and smell [taste is questionable]. However, we predominantly use the idea of sight to cover the total input from the other senses as well as seeing. We 'see' the whole picture when we are

talking about holistic care of patients. I had the idea of 'seeing' the assessment through various 'eyes'; whose eyes nurses 'see' through determines what they see. Taking a point of view is still about 'seeing'. The darkness is not completely black because nurses who use their eyes to look specifically for pain cues can get hints to help them guess patients' pain experience. This is important because some nurses look while others do not. Looking is determined by motivation and access to different 'eyes'. Even when looking, some nurses 'see' while other nurses miss the cues.

From an empirical stance, the only way of 'knowing' is seeing [physically with my eyes] whereas 'knowing' through words and conversation is a more abstract understanding. Are the images we 'see' in our minds based on words? People say 'I see' when they have a better understanding ['ah-ha']. Language is a way of communicating what we are seeing. Does the concept of 'seeing', equating to understanding, depend on whether people are basically visual, auditory or tactile?

In this situation what can we see? Depends if our eyes are open or shut (either way we see darkness). If our eyes are shut, we can still 'do' care with our hands. The care may be what is expected to be completed by the end of the shift. We may have tunnel vision and have shut eyes to the patient but open to our colleagues' expectations of us - wanting to be judged as a 'good' nurse. If our eyes are open we may see darkness because we have no way of knowing for sure what the patient feels. The shedding light that comes about with connection allows us to 'see' glimpses of what the patient might be feeling. The more light is shed, the better our assessment of this patient. Even if no light is shed, we still do our care.

Working in the dark means that we are unsure if we have chosen the right care for this patient. If our eyes are open, we would prefer to have more light so that we could feel better about our efforts. If our eyes are closed they may be asleep [neglect through ignorance] or they may be closed because we have chosen to shut them [neglect because it is too hard or not important]. Sometimes we shut our eyes because it makes no difference to the amount we can see if we have them open and it is less effort keeping them shut than trying to see in the dark.

Motivation comes from peer appraisal [a good nurse is one who has a comfortable patient], internal belief that pain management is integral to nursing and therefore consistency in behaviour with that belief leads to less stress, a coping mechanism of reducing uncertainty by increasing knowledge, and/or emotional closeness to patient

and/or family. Motivation for not looking results from beliefs around the relative unimportance of pain management to life saving measures, the unlikelihood of pain sequelae, emotional distance from patient or family, or a coping style that can function easily without having to relieve uncertainty.

Access to different eyes results from knowledge gained through experiences of nursing and personal encounters with pain. These experiences vary across nurses and although some can be orchestrated others cannot. The basic education of nurses before registration can include instruction on pathophysiology of pain and time spent with patients suffering different medical conditions. However, what nurses actually glean into their repertoire of nursing knowledge depends on a multitude of other factors including: how receptive they were, what was on offer to learn and the relationships formed. Life experiences and patients encountered post registration are different for each nurse and what is absorbed by each nurse in the form of knowledge to inform practice varies with that nurse's response to the encounter. So what each nurse 'sees' is based on an accumulation of knowledge resulting from past life and nursing. Such a variation cannot be levelled out or controlled. This variation can be seen negatively as resulting in pain management practice that does not reach a minimum standard of care or it can be seen positively as a wealth of knowledge to be tapped into and shared among nurses to enhance the pool of nursing knowledge regarding pain management. What sort of research would tap into this diverse knowledge? Would the pool of knowledge based on such research be the evidence needed for evidence based practice? Or would it be so diverse as to be irreconcilable?

5.1.2.7 Developing the concept of the satchel

There is a lot of information available about pain care modalities; books have been written on how to manage pain, nursing texts list ways of promoting patient comfort and alternate therapies provide other options. Nurses come 'armed' or have at their disposal various actions that they can 'do' to patients to move them towards a more pleasant state. The nursing profession does not have total access to every available tool because legally doctors control the administration of drugs. Each nurse comes with a different content in their satchel. Treatment modalities go into their satchel when they learn about them or become proficient in them, for example, not all nurses can do a face shave on a male patient with the skill needed to make it a comfortable procedure. Some 'tools' may never make it to a particular nurse's satchel because the nurse has never been exposed to them, for example reflexology. So the wider nurses'

experiences in nursing and in life, the more ‘tools’ will be in the satchel. [See Table 5.1.1]

Table 5.1.1 Possible tools in the satchel

how to talk to patients and what to say
how to position a patient
how to do hygiene care
when to cover with blankets or leave patient exposed
how to maintain the patient/technology interface
sedation
analgesia
manner and methods in nursing procedures
aromatherapy, reflexology, massage

It is interesting that both connection and the tools in the satchel depend on experience and learning and vary with each nurse. Connection makes us want to dig deeper into our satchel to do as much as we can for patients, but if our satchel only has a couple of things in it, it matters little how connected we are, we will not be in a position to help as effectively as another nurse whose satchel is full. On the other hand, if our satchel is full and we have diminished connection with this patient, the tools are of no use to us because we do not get them out or we do not know which ones to use. If we have a full satchel and we are stopped when we want to use a particular tool, we become frustrated, for example, when doctors limit analgesia and sedation or the particular culture of the unit does not allow alternative therapies [instead of doctors removing things from our toolkit, they stop us using specific ones which relates to nurses working with their hands tied]. If we are new to nursing and have not developed the repertoire of nursing skills to promote comfort and predominantly rely on pharmacology, when the doctors limit the use of analgesia or sedation we may not have much to fall back on.

5.1.3 Attempting to expand the metaphor

In light of the developing concepts emerging from the metaphor, I tried adding more words into the actual metaphor to share these ideas. I have included the attempt here but I prefer the original form of the metaphor as above. I named this a ‘metaphorical story’ because even though there was one main concept of ‘darkness’, there was a temporal flow.

5.1.4 Metaphorical story

ICU is a place where there is a lot of light. At night it is as bright as day because the fluorescent lights are glaring. Parts of patients are spotlighted for a clear view when procedures take place. Lights on the equipment communicate technological functioning or draw our attention to changes in the medical condition of patients. Even the inner body of the patient is brought to light with our understanding of complex processes and treatments. However, there is a dark room in ICU where we go when we contemplate the comfort or pain that ICU patients experience while they are unable to tell us about it. Not all of us enter this room, having never seen it, being obstructed from approaching it by life and death crises, not having the energy to take the necessary steps or just preferring to nurse in the 'light'. Upon entering, we can only see the silhouette of the patient. (Some of us have better eyesight than others because of our experience and knowledge). We may try to put on different eyes in order to see better – eyes belonging to the patient, their family, our colleagues. The picture of the patient that we see in our mind's eye is the best guess based on a summation of what all the eyes have seen. When we enter this dark room, we have with us the tools we use to treat pain and make our patients comfortable. (Some of us have more tools than others because of our experience and knowledge). These tools include talk, touch, analgesia and sedation. What we do with these tools depends on the picture of the patient we have in our mind. Sometimes doctors prevent us taking pharmacological tools into the room leaving us with the frustration of working in the dark with our hands tied.

5.1.5 Summary

The first of the findings, in chronological order, was the metaphor. Metaphors can jolt us into different patterns of thinking and being. The dark room metaphor provides a visual image of what it can be like for nurses to care for pain in unresponsive patients. The next section 5.2 presents our collective story.

5.2 Collective story - *creating the blend*

This section presents the collective story of our care of pain in unresponsive patients together with the tensions evident between the issues the collective story raises. The collective story concerns a unique nursing situation where applicable scientific knowledge is limited, relationships between nurses, patients, doctors and others impact on care given, nurses differ in their practice and therefore patients receive a diversity of care. My struggle in finding a suitable way of structuring the complexity in the story, how the story was received and my attempts to enliven the story were discussed previously.

My theoretical position is that we live surrounded by stories and these metanarratives or cultural stories impose themselves on our lives. We also live our own stories and they are told in personal narratives; we tell stories of fragments of our experience in order to communicate a particular point. The process of collating and ordering all the concepts from the interviews into a collective piece contained both the notions of representing the metanarrative and representing the individual by interspersing anecdotes to illustrate points made.

5.2.1 The collective story

Our story happened within a large city teaching hospital, inside a general, adult intensive care unit where we worked as nurses caring for critically ill patients. Specifically, the story is about when we looked after the comfort or pain of those patients who were unable to respond to us in a way that we could understand, and that indicated to us that they were aware. Their unresponsiveness was caused by pathophysiology, drug induced sedation or paralysis. I called these patients ‘non-purposive’.

[See section 4.1.5.2 for an explanation of the change of terminology to ‘unresponsive’]

We worked a variety of shifts, both days and nights, and we were often assigned by the shift leader to take care of different patients each shift. As we approached the patient that had been assigned to us for the shift, we experienced different levels of connection with our patient’s experience of comfort or pain. On a one-to-one basis, as we spent more time with a particular patient, we were able to create a more distinguishable picture of our patient’s experience. Depending on which patients we were assigned to take care of, we were with them for eight or

ten hours, and some over days or weeks on an intermittent basis. Our unit did not practice continuity in caregiver to patient relationships. One thought was that pre-operative visits would have helped us to know our patients better and would have helped patients be prepared and thus more comfortable with ICU happenings.

Because our patients were not able to communicate directly and the comfort or pain cues they exhibited were subtle, we found assessment of comfort or pain levels to be difficult, however we also felt more responsible for our patients' comfort and pain than those capable of direct communication. This responsibility motivated us to attempt connection with our patients.

When our patients' relatives visited or phoned, we increased our focus on comfort and pain and used our contact with relatives to 'see' our patients as whole people. However, the relatives often needed information and reassurance which sometimes directed our attention away from the patients. If we imagined our patients to be like one of our loved ones, we felt like putting more effort into their comfort or pain care, whereas, if they threatened us, behaviourally or pathophysiologically, we felt less inclined to do other than what was necessary.

Those of us who had personally experienced situations that our patients were in, used the insight obtained to connect with what they may be experiencing. Others of us established a link through imagining what it would be like to be the patient. Our imagination was educated through previous awake patients we had nursed, memories patients had shared of their ICU experience, and our theoretical knowledge. We thought our theoretical knowledge could be improved with more in-service tutorials on pain.

Because some previous ICU patients retained memories of events during the time they were non-purposive, we assumed our patients were aware and able to experience comfort and pain. We also thought it would help us if more of our patients would come back and tell us about their experience of ICU, however, we were aware of one likely hindrance to this occurring if they were faced with the tension of being thankful for their lives but possibly critical of our care.

Although we knew that each patient's experience was individual, individuality

was not readily detectable in our patients, so we tended to group patients and make assumptions about their comfort and pain experience based on their age, gender, culture, hospital experience and pathophysiology. Specifically, some of the views held included: older patients feel less pain, males experience more pain, Asians are stoical and Arabs are demonstrative, those with less experience of hospital put up with more than those who knew the system well. We thought of some conditions such as patients with renal colic, multiple fractures or surgical patients, especially oesophagogastrectomies or patients with intercostal catheters experienced the most pain. We also thought that routine procedures such as turning, suctioning, cannulation, and arterial puncture were not experienced as routine to patients and often produced distress. Tissue damage via pathophysiology, surgical wounds, the presence of an artificial airway, and other invasive lines, tubes and drains caused various levels of discomfort.

There were specific signs that indicated to us our patients were uncomfortable or in pain. We usually watched for these signs in association with those procedures we thought would cause discomfort. Knowing that pain causes stimulation of the sympathetic nervous system, we noted hypertension, tachycardia, tachypnoea, diaphoresis, and dilated pupils, although we also knew that there could be causes of these signs other than pain. From our knowledge of pain behaviours, we noticed restlessness, tension, and facial grimacing. Some of the doctors did not agree that grimacing indicated pain in patients who were uraemic. When our patients became long term, we considered whether their pain would be acute or chronic. When there was nothing else to observe that indicated our patients' experience of comfort or pain, we relied on gut feelings or instinct.

Within our unit, doctors enjoyed a higher and more powerful status than us and were perceived by some of us to have superior knowledge. Being legally in control of administration of medications, at times, usually to promote patient recovery, doctors either withheld or limited administration of narcotic analgesia or sedation. It was during these times that they sometimes discredited our judgement of our patients' comfort and pain experiences. However, we did spend more time in contact with our patients than the doctors who made decisions based mainly on their observations during the twice daily rounds. We did not

help in the accuracy of these observations as we prepared our patients for the doctors to view. The patients were positioned on their backs, neat and clean and not undergoing any nursing procedures while the doctors were present.

Although the doctors were in contact with our patients for a much shorter time than us, they did not acknowledge our contact time as an important assessment factor.

With this discrepancy in assessment, we were left to deal with restrictions on the amount of drug we could give and also had to cope with nursing a patient we thought was in pain.

The available paperwork was ineffective for the documentation of pain and sedation because we found the complex interrelation of what we observed in our patients, what we knew from our experience and learning, and what we gleaned of their personhood was unable to be contained within our unit's specific chart.

Finding the process of determining our patients' experience of comfort or pain to be difficult, we fantasised about an effective, objective assessment tool which would measure our patients' comfort levels. Some suggestions were to statistically average awake patients' responses to different procedures and use the results on unresponsive patients, to measure endorphin levels or continuously measure neurotransmission that equals pain. However, the realms of fantasy did not help us deal with the reality of nursing our patients in this situation.

Our assessment of our patients' possible pain or comfort experiences were based on the connection we achieved with them. Because we came with varying backgrounds, we were different people, had divergent experiences and dissimilar knowledge levels, we each had unique abilities to connect with our patients. The connection achieved was as individual as the nurses and patients involved.

Based on our connection with our patients and what we believed our job to involve, we had different levels of commitment to helping our patients be comfortable. Either judged by our peers or within ourselves, caring for a comfortable looking patient showed that we were good nurses. Although,

acceptable excuses for an uncomfortable looking patient included time and emergencies. Still, our patients were usually in the unit in order to recover, and from time to time there was tension between our role to provide comfort and the ultimate aim of recovery for our patients. Again, our connection with our patients helped us determine which goal was more important at this time.

Having determined what we thought to be the best guess of our patients' comfort or pain experiences, what our role expected of us, what the plan for patient progress was, we then intervened. The comfort and pain management options we used for our patients and how we applied them also varied depending on our experience and knowledge.

We thought narcotic analgesia together with sedation were the first choice and most potent comfort measures for our patients. In our unit, morphine was the narcotic and midazolam was the sedative of choice. However, we wondered whether other drugs or routes would be better in some circumstances, for example, epidurals would cause less patients to be unresponsive, but we thought alternatives should be based on research. Our knowledge of the pharmacology of narcotic analgesia and sedation was formally taught to us as well as experienced via previous patients. We based our administration decisions on this varying knowledge. Although we seemed to have a degree of flexibility with the written orders, doctors maintained reasonably tight control through the use of verbal directions during rounds.

We were sometimes unsure of the exact goal of analgesia, especially when we were given conflicting orders by the medical staff. We wanted our patients to get better, and we knew that keeping them completely comfortable with the available drugs could retard their recovery, yet we were also aware of the detrimental effects of pain. Often it was not possible to have a pain-free, recovering patient. Some of us wanted our patients to be completely pain-free while others wondered if they should aim analgesia during nursing procedures rather than when our patients were undisturbed and looked comfortable. At other times, we didn't know what to aim for as we didn't know where the patient was at.

Sometimes we were guided by a vague notion that too much narcotic analgesia was bad. Hesitation in giving narcotic analgesia seemed to stem from a lack of

pharmacological knowledge and we thought some inservice education on pharmacology could be helpful. We thought giving too much narcotic analgesia stressed the body to metabolise it and possibly caused addiction. Other hesitations were more soundly based; respirations decreased, level of consciousness lowered and vasodilatation caused a drop in blood pressure. However, technology and other support for patients in ICU allowed us to deal with side effects of respiratory depression and hypotension in most cases, so some of us thought there was no problem with being generous with narcotic analgesia.

When determining the exact dose of analgesia to give our patients, we considered the patient's body size and possible physical causes of pain, such as tissue damage and nursing procedures. We were guided by similar awake patients that we had previously nursed to give a baseline for administering analgesia, then we titrated the dose to any indications from this patient. Some of us gave analgesia for comfort rather than just to relieve pain. However, we were also aware of the possibility of actually causing discomfort with narcotics when nausea resulted. It was difficult for us to differentiate between cues for nausea and pain and usually we would treat for pain rather than nausea.

Sedation was often put together with narcotic analgesia as a treatment package. Morphine and midazolam were usually administered together in a single infusion which caused us to often view them as a unit. We gave narcotic analgesia and sedation as a priority when our patients first arrived in the unit because they were unlikely to have reasonable levels in their body and we wanted to minimise the negative effects of the stress response caused by anxiety and pain. An added benefit of sedation was to make our job easier; sedated patients were easier to ventilate and they lay still. Although we assessed and treated what discomfort we thought our patients were experiencing, we also hoped that they would not remember experiencing ICU. We considered sedation useful in causing patients to be hopefully unaware or forget, especially when our patients were pharmacologically paralysed.

At times narcotic analgesia and sedation was decreased or stopped at the request of the doctors who wanted to wean ventilation in a view to extubate our patients, assess neurological status accurately, or when patients had liver or

renal failure. Some of us thought it was better for our patients to put up with a little pain in order to be extubated, whereas others preferred to treat the pain, leaving patients intubated a little longer. We often assumed our patients would be experiencing pain when 'awoken' for neurological assessment, especially if they had causes of pain other than their head. In those patients with liver and renal failure, we understood that restricting these drugs would prevent the liver from further stress and metabolites from building up in the body because of lack of renal clearance. This understanding helped us to justify nursing patients when they appeared to be in pain.

In opposition to our nursing mandate to relieve pain, we sometimes found it necessary to inflict pain on our patients. Especially for those patients whose analgesia and sedation was limited, we had to cope with incidentally inflicting pain when we changed their position in bed, gave hygiene care, or attended to their dressings. We also had to cope with actually intending to inflict pain when assessing for conscious level in neurologically injured patients. We questioned the need to inflict pain for neurological assessment, wondering at what point patients would no longer be unstable in their brain function. We coped with inflicting pain, whether it was through intention or not, by focusing on the benefits of our actions rather than the pain our patients felt.

On the other hand, when there was no benefit to the patient because they were dying, we focused completely on comfort. We believed that the very process of dying was painful. We usually gave analgesia and sedation liberally because the tension between comfort and recovery was eliminated; we did not want dying patients to experience any discomfort. When giving generous amounts of analgesia and sedation, we were not sure whether at some point providing comfort turned to killing.

In any of these patients, dying or recovering, there were options, other than drugs, which we used to promote comfort. We positioned our patients in bed and frequently changed their position, kept them clean, touched them and talked to them. Which options were chosen depended on our connection with our patients, our knowledge of physiology, what we had seen work before and what we imagined to be beneficial, in conjunction with routines of the unit and time available to us.

When we moved patients in the bed, we tried to be gentle, placed patients in a position that appeared in alignment and was supported by pillows and mattress, and made provision for attachments. However, what we imagined to look comfortable may not have felt comfortable for our patients depending on their usual sleeping habits.

We usually gave hygiene as a reflection of what we would like to have done for us. Some of us thought more about the 'extras' like hair washing and foot baths. Males seemed to put more emphasis on shaving. During hygiene we were able to notice and treat skin or mucous membrane problems that would cause discomfort.

Some of us gave a 'back rub' to our patients during repositioning and hygiene, others talked about the benefits of body or foot massage, although there often wasn't time. However, some of us were also sceptical of the benefit of our 'unskilled' massage to patients who were so seriously ill. We also thought about other alternative therapies such as aromatherapy, although we were aware of our fairly traditional environment which was restrictive on innovations.

Because of the frequency of nursing procedures to our patients, we were aware that it was easy for us to minimise the patient impact. When we talked to our patients as a preparation for nursing procedures, what we said to patients usually minimised what the procedure involved, however we did consider that the continual disruption would in itself cause discomfort.

Whatever options we had used to promote comfort and treat pain in our patients were based on what we knew and how we connected with them, so our care varied. Because they were not responding, we were unsure and found it difficult to know for certain if our patients were comfortable or not. We were not privy to immediate feedback from our patients in order to evaluate our care, instead we had to live with not knowing for sure what their experience was while under our care.

5.2.2 Collective tensions

While working the collective story into a manageable format, I noted points of tension between issues that nurses presented. These tensions, although just outlined in Table 5.2.1, are analysed further in light of dialectic thinking in the explanatory findings.

Table 5.2.1 Points of tension in the collective story

Good nurse versus bad nurse	being judged a ‘good nurse’ by others versus keeping patient alive versus own needs [looking busy versus disturbing the patient] [sedation makes them lie still].
Actual patient experience versus evidence that we can see	lying still looks comfortable but could be in pain. There is no indication and when we do see indicators of pain it could be something else. Knowing that this patient is an individual but having to generalise by putting them into a category or group in order to guess their pain, generalising from our experience to this patient to assessing and guessing what might help. Our resources for generalising vary and our guess might be completely wrong.
Like versus dislike patient	relatives can impact on us liking the patient by filling in the picture of what the patient is like and focussing us on comfort, or they can make us dislike the patient or take our time away from caring for the patient.
Look hard versus look away	ambiguity/uncertainty/unknown quality of patients’ pain makes us more responsible or ignore. Coping with uncertainty may mean avoiding [we do not see or believe they cannot experience pain] or trying harder to work it out [we want a measure – a screen and an alarm!].
Experience now versus remember later	whether patients can remember [whether they would tell us anyway] versus what they actually experience at the time [midazolam for amnesia].
Keeping versus changing patients	continuity giving a sense of history and knowing the patient versus excitement of variety and change and not having to deal with a hard patient every shift.
Goal of comfort versus goal of cure	Pain/living/recovery versus lack of pain/death. How much pain is OK? Fear of killing. Inflicting pain versus relieving pain. In trying to relieve pain by using narcotic we can cause the discomfort of nausea. Too much narcotic is bad versus too much pain is bad. Doctors’ focus/contact time/contact circumstance/time trajectory/power versus nurses’ focus/contact time/contact circumstance/time structure/powerlessness impacts on communication – we speak different languages – different assessments and different goals – different doctors have different goals – goals can change – the seeming inadequacy of nursing resources for pain care to doctors [nursing care versus narcotics].
Minimising because blasé versus diminishing anxiety	nurses minimising the impact of their care [by discounting it to themselves – familiarity] versus nursing minimising procedures through talk [to decrease patient alarm and anxiety] [numbing our minds’ eye or numbing their’s].
Complexity of assessment versus simplicity of chart	[no pictures] - what doctors require versus how nurses work – the end point may be the same but the communication and execution can be at crossroads.

5.2.3 Summary

The collective story synthesised eleven individual nursing stories to share the complexity of caring for pain in unresponsive ICU patients. The complexity was manifested in the multiple points of tension between issues apparent whilst shaping the collective story. The complexity continued to emerge as I worked with ways to present a discussion of such issues. The explanatory findings, present a chronological journey though my struggle to contain the complexity within words [and sometimes illustrations] on a page. Like taking photos from several angles, each attempt of the various schematic approaches added depth and width to my thinking so that the end result holds the most complexity of thought. Before delving into such explanatory complexity, the next section presents the last of the expressive findings of this study in the form of an arrangement of nurses' metaphors into poetry.

5.3 Poem - *expressing the pain*

Being inspired by the manner in which the 'dark room metaphor' promoted deeper understanding, I looked at the interviews and found metaphors that the nurses used. "Metaphor *coins* words and turns language into a currency by turning one expression into an equivalent term and exchanging one term for another" (Armstrong, 1993, p179). Because my personal experience of writing poetry has often been to provide an outlet for strong emotion and because metaphor is an essential element of poetry, after categorising the nurses' metaphors I arranged them into a flow of poetry that made sense to me. Explanation of the writing of this poem was outlined in the method section.

5.3.1 About poetry

Poems can explore feelings, emotions and actions in a complex and rich way through the use of imagery. In the dialect between poet and listener both contribute to the way images form in the mind. Vivid images can remain in our minds. Poetry has been used as a way of healing through expressing what is painful (Harrower, 1972; Mazza, 1996).

5.3.2 The poem

look the other way	(1:13,8)
ignoring it a bit	(5:1,34)
couldn't pick up	(4:4,7)
locked into this automatic pilot	(5:9,16-17)
it slips into the background a little bit	(5:7,3-4)
palm it off onto someone else	(9:6,11)
look at it again	(5:20,24-25)
your eyes opened	(8:14,18-19)
a whole picture.	(1:8,4)
leaping around in the bed	(1:7,17)
climbing out of the bed	(1:5,7-8)
going berserk	(3:5,9-20)
blood pressure sky high	(5:8,30)
screaming tachycardia	(2:8,35-36)
trying to wrench their guts up	(4:14,24)
fighting	(8:22,27)
gasping for breath	(8:20,28)
as stiff as a book	(7:3,5)
its going to nag	(8:26,33)
living torture	(8:9,5)
put yourself in their shoes	(4:8,10)
help them along	(4:4,16)
down the lane	(8:2,31)
there's a fine line	(2:13,3)
really fine line	(5:7,36-37)
find that fine line	(4:21,13)
hard to know where that fine line is	(8:20,4-5)
get them to a peak	(4:9,36)
to the edge	(4:6,35)
overstep that line	(4:6,33)
over the cliff	(4:6,33-34)
can't find that fine line	(8:14,5)
verging over the top	(4:9,37)
over the edge	(9:13,27-28)
overboard	(4:9,31)
come back down a little bit	(4:10,1)
got to top them up again	(4:9,23)
so fine a line	(4:6,32)
catch 22	(6:13,32)

your abdomen is right open	(5:7,27)
just pumping pain relief and analgesia	(9:8,19)
covers your pain	(10:3,19)
none of this dangling a piece of cake	(4:20,21)
knock off your memory	(10:8,14)
combat	(5:7,20)
it is pretty hit and miss	(8:7,13)
bound to have hit it right somewhere	(8:7,19)
a bit under	(1:6,5)
way off	(8:7,23)
a bit spaced out	(4:8,7)
too bombed out	(6:4,10)
people losing blood pressures	(1:7,35-36)
make them into a contortionist	(4:7,11)
your liver's shot	(4:19,32)
fairly encephalopic	(1:6,5)
just rotting away	(9:15,6)
pulled out on	(8:21,18-19)
I'm not gonna let this pain, you know, linger	(3:7,27)

5.3.3 Responses to the poem

When I shared the original version of the poem with my supervisors and later at the university faculty research seminars, the response was tangible strong emotions and the words spoken to me included 'powerful' and 'moving'. Writing the poem helped me to feel the depth of difficulty we experienced as nurses at times in response to caring for unresponsive critically ill patients in pain.

5.3.4 Summary

The metaphor, collective story and poem present the findings of this study in expressive form. Together they express how it is for us to be uncertain yet needing to take action and hoping we get it right for the patients' sake. The next section 5.4 presents the findings of this study in explanatory form through a demonstration of the deepening of my thinking over time and forming of concepts towards synthesis.

5.4 Focus - *presenting the issues*

The expressive findings of this study presented as metaphor, collective story and poem exposed the complex realities of nursing unresponsive patients' pain in ICU. The metaphor provided a word picture to allow visualisation of the factors that add degrees of difficulty to nurses both 'seeing' and 'doing'. The collective story described the nursing viewpoint when encountering the possibility of pain from the perspective of nurses engaging with their inner selves, with patients, patients' families and doctors. The poem paved the way for emotional understanding of the difficulties and frustrations faced by nurses. The expressive findings ended with uncertainty.

During my candidature, I struggled with the selection and presentation of issues for discussion in this study. This final section of the findings is explanatory in form and shows the progression of concepts and visualisations that led me to a clearer understanding of the emphasis of this thesis. At this stage I do not refer to the literature or quotes from the participants as the full discussion is contained within Chapter 7. Here the formational thinking presents with clarity the complexity within this thesis. This section shows my journey of analysis towards the insights I gained into all that is involved in the situation of nurses considering the possible pain of unresponsive patients. Pictures and colours seemed to be predominant in my thinking leading to sections of writing based on the metaphor and a display of diagrams.

5.4.1 About the 'nursing process'

The first summary of issues for discussion followed the cycle of assessment and management as portrayed by the 'nursing process'. In the 'nursing process', nurses assess patient needs, implement management options and evaluate the effectiveness of their care based on patient outcomes; the evaluation equates with assessment for the next cycle. I organised the information from participants accordingly with thoughts on assessing pain [seeing] and then on managing pain [doing]. The narrative nature of the study led me to attempt to align these thoughts within what I believed would be the overriding metanarratives.

5.4.1.1 Nurses are individuals

You who are caregivers understand that your contacts with patients do not take place in a vacuum. They take place in a rich context of personality and personal history and immediate, existential circumstances. Only story can convey this rich reality.
(Krysl, 1991, p34)

As I talked to my colleagues, I was struck by how each of these nurses was so different from each other. They showed me that the job of nursing is one where the whole person of the nurse is very involved in the actual ‘doing’ of nursing.

Nurses portrayed how they are human and have their own needs and feelings which vary day to day and impact on their work. Although each had been trained or educated in basic nursing, and some had completed further education; tertiary or specialised certificates, what seemed to make the most difference was the happenings they had experienced along the way, either in their personal lives or in nursing.

These happenings shaped what these nurses’ eyes saw, what they thought they should do and what they believed they could do in their nursing practice. So nurses come to their job bringing themselves in terms of their own needs and feelings as well as their own ideas and their individual way of thinking.

5.4.1.2 Nurses are human

Nurses spoke about how they are sometimes physically or mentally stressed. Without considering personal stressors, nursing itself is a demanding job. Physically, there are the negative effects of shift work, lifting heavy patients, being on your feet for eight or ten hours, reaching and bending in an ergonomically not ideal work area. There are times when nurses need to sit down because they are tired, especially on night duty. Mentally, nurses are under scrutiny from nurses above them, their colleagues, doctors and relatives of the patients. Because it seems that nurses judge a good nurse by how comfortable the patient looks, it helps stress levels if these patients lie still (look comfortable) rather than wriggling and looking generally messy - so sedating these patients helps with nursing them. Abusive patients can threaten a nurse’s self, empathy is difficult and coping often occurs through distancing. If personal factors are added in, it is obvious that nurses have good days and bad days just like anyone else.

Sometimes nurses may not look at patients’ level of comfort until it becomes obvious. However, this omission would not necessarily be the case all the time. On other days with different patients, nurses may be more in tune, have more energy, think more clearly, or be more focussed. The story these nurses live is not static and set in time.

metanarratives

A good nurse is busy all the time
 A good nurse has a comfortable looking patient
 A nurses’ personal life must not impact on work (but it does)
 Bad days are not allowed

5.4.1.3 What nurses can see

Eyes see differently, depending on experience and learning. Experienced nurses tended to see more cues. The pain cues listed by these nurses included; tachycardia, hypertension, sweating, restlessness, tension, large pupils, grimacing and tissue injury, as well as their own imagination. If nurses had personally experienced something that causes discomfort, the same experience in others is less likely to be minimised. Some nurses can imagine themselves as the patient more vividly than others. Doctors often see differently from nurses, which can cause conflict, for example, grimacing attributed to uraemia. Sometimes doctors discredit what nurses see. Does that mean that doctors' eyes are worth more than nurses? But nurses have more contact with the patient and time spent looking means more is seen. It is hard to write down what you see on the paperwork available. What should be done about documentation?

Nurses can train their eyes to see through education and experience. To avoid minimising patients' pain nurses could: gain more general nursing experience in a variety of settings, seek familiarity with subtle pain cues, personally try some of the routine procedures of ICU, for example, blood gas sampling, be aware how personal life experiences impact on nursing care and talk about these experiences with others and listen to patients talk of their experiences in ICU.

metanarratives

A nurse is a nurse (but nurses are different)
 Doctors are more important than nurses
 Only what is written is believed (nurses talk / doctors read)

5.4.1.4 What nurses think they should do

Nurses told of their belief that it is their job to relieve comfort; they often judge a good nurse by a comfortable patient. However, nurses justify some pain in these patients, and inflict pain themselves at times. Nurses perceived a tension between comfort and recovery in ICU patients. Nurses want these patients to forget (or hopefully be unaware) of anything unpleasant, and if the patient is dying they want them to be oblivious and the death to be quick. Nurses think all patients should be treated equally (by nurses and doctors).

metanarratives

Nursing = providing comfort
 All patients should be equal (but some are more equal than others)
 Getting better hurts and patients have to put up with some discomfort
 Dying hurts but you shouldn't have to feel anything
 Wiping out patients' memory of pain helps nurses cope with seeing patients in pain

5.4.1.5 What nurses believe they can do

There are differences in what comfort measures the nurses think could be beneficial to these patients. What does the literature say about positioning, turning, hygiene, touch, talking and minimising as methods of providing physical comfort? Are there other options these nurses discounted or did not mention? Are there factors within these nurses or in the environment that hindered the use of other methods of comfort care? Some nurses feel restricted by unit protocols. Confidence is needed when arguing with the doctors for more analgesia or sedation, both of which the doctors control. Confidence is also needed when talking to relatives. There are different confidence levels amongst the nurses.

Nursing confidence can be increased by:

1. education and experience (sharing personal experiences, getting patients to talk after recovery about experience in unit)
2. research based practice (which drugs are best, what other measures are good for what problems)
3. breaking out of protocol thinking.

metanarratives

Any other comfort care than routines are time consuming and of unknown benefit
 Innovation is discouraged
 Research based care is discouraged
 Doctors control medications and some are not easily influenced by nurses input
 (doctor/nurse game)

5.4.1.6 Uncertainty

Nurses said they cannot be totally certain of patients' pain therefore we need to know how to decrease uncertainty or deal with uncertainty.

metanarrative

The scientific method calls for certainty

The following two pages contain a visual map of the issues around the concepts of nurses 'seeing' and 'doing' in relation to patient's pain.

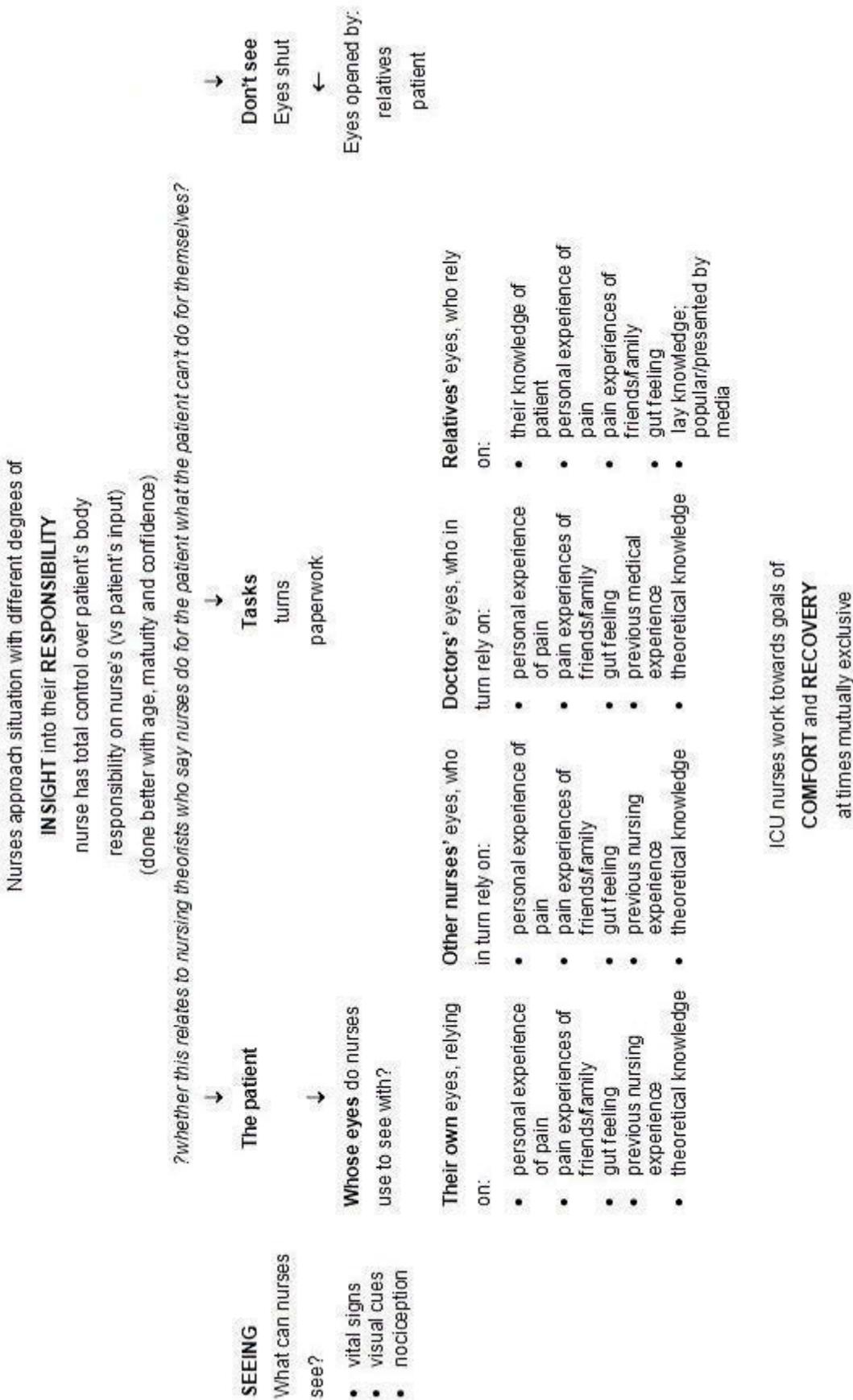


Figure 5.4.1 Nurses' seeing

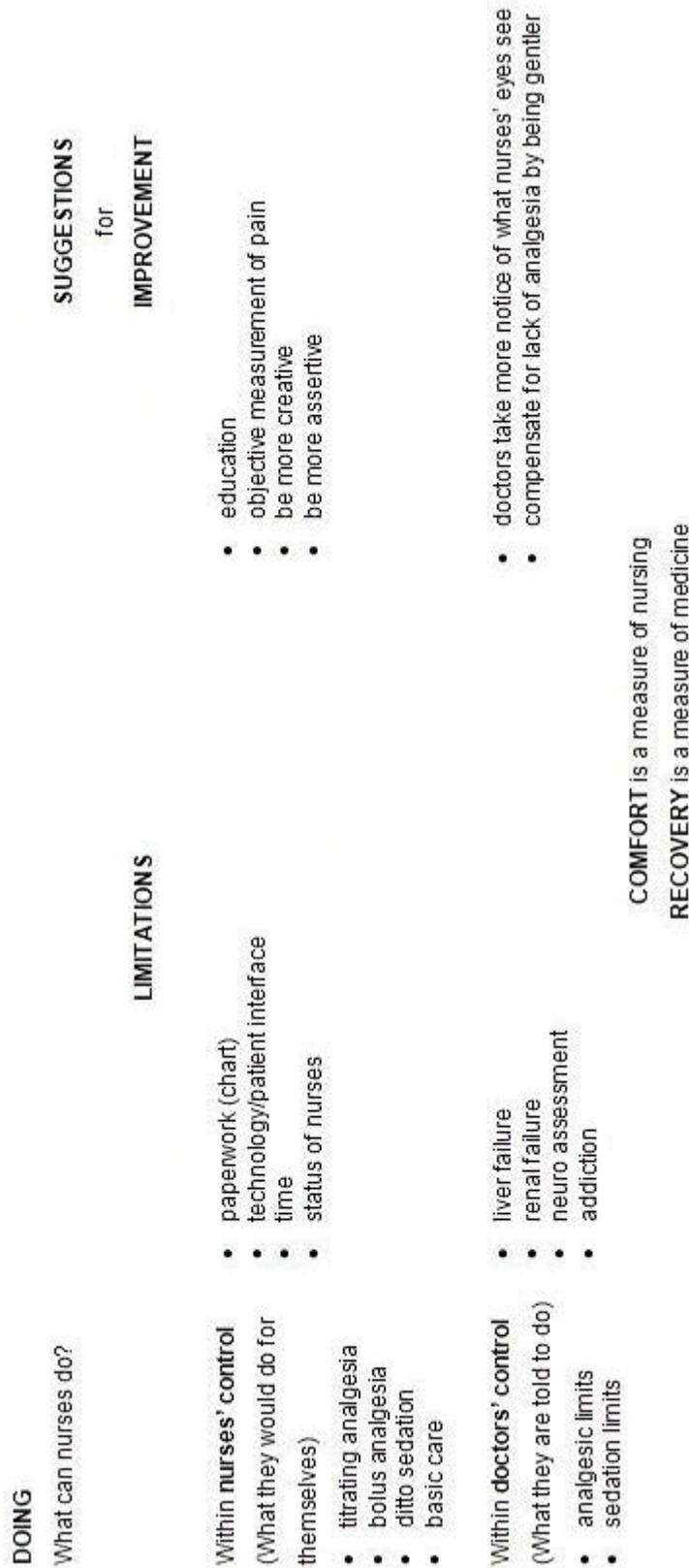


Figure 5.4.2 Nurses' doing

5.4.2 About expanding on concepts from the dark room metaphor

While attempting to organise issues raised by the nurses around the nursing process in terms of 'seeing' and 'doing', my focus was mainly on the uniqueness and difficulty of assessing pain in unresponsive critically ill patients. Noting that nurses differ in their practice, because the applicable scientific knowledge is limited, and that relationships between nurses, patients, doctors and others impact on care given, I became concerned about the outcome of diversity in patients' pain care. Having formed the metaphor as presented in 5.1, I moved to organising my thoughts for discussion centred on this dark room. During this development, I expanded on each concept from the metaphor such as: darkness, entering, silhouette, contents of the satchel, accessing the satchel and lighting the room, and thought of bodies of literature that would shed light on issues arising from each dark room concept. I have included ideas for literature in square brackets but have not cited any literature here as full discussion of issues with relevant literature is presented in Chapter 7.

5.4.2.1 *The darkness*

There was, at commencement of this study, very little knowledge regarding the experience of unresponsive critically ill patients. [Studies of memories of ICU patients.] If individuality of pain experience is acknowledged, then each patient's experience must be taken on its merit. The pain experience at the time which is unable to be assessed is what the nurse is attending to, rather than the memory which may be recalled later when communication is possible. Assessment is difficult because of the lack of pain cues from these patients.

5.4.2.2 *Entering the room*

Comfort is a nursing role and the nurses use patient comfort as a measure of a good nurse.

Nurses are with these patients most of the time, although change of shifts and rotating allocation results in different individual nurses taking care of these patients.

However, pain and comfort is not always a top priority in ICU. Nurses are responsible for decisions regarding pain and comfort, however, saving of life takes precedence. [Literature on priority nurses give to pain.]

Nurses are also human and have times during shifts or days when they are tired and not zealously motivated to be 'super-nurse'. At these times, the nurses may not

consider pain and comfort in these patients to be a priority; instead they may focus on tasks that need to be completed. [Literature on levels of energy contributing to amount of care given - motivation, stress, fatigue.] Having an uncomfortable patient can also stress nurses because they are judged as inadequate in their practice.

5.4.2.3 *The silhouette*

Sometimes these patients give no indication of their pain or comfort. They lie still or are pharmacologically paralysed, and have normal vital signs. At other times, behavioural and physiological cues exhibited by these patients are subtle and can originate from causes other than pain or discomfort. As an individual nurse spends more time with a specific patient indications of comfort and pain may become clearer. These patients certainly cannot tell the nurses of their experience of pain at the time.

Although the nursing profession's rhetoric includes an ideal of 'quality nursing practice to all patients equally', the care nurses give and the time spent considering patients' pain and comfort may relate to the extent to which nurses find patients attractive. [Literature on ethics.] Attraction can depend on similarities to the nurses' self or a member of their own family, whereas, lack of attraction can result from threatening behaviour or pathophysiology of patients. Patients' relatives also contribute to the amount of attraction by telling nurses the patient's story or by irritating the nurses, interrupting their work or asking unanswerable questions.

5.4.2.4 *The nurses' satchel*

What the nurses 'do' for these patients' pain and comfort depends on what they interpret these patients to be experiencing and what management options they believe to be effective.

5.4.2.5 *Filling the satchel*

The nurses' skills of pain assessment and management seemed to be learnt mainly through experience. [Literature on how nurses learn practically.] Nurses are individual in what they base their practice on because their experiences differ. This is not dissimilar to other skill acquisition, for example, parenting can be based on literature, media, observed experiences of family/friends or one's own experience of being parented; and each parent is different. [Skill acquisition literature.]

The nurses suggested how they could improve their repertoire of experience; by learning from awake patients, listening to patients post ICU and reflecting on and sharing personal experiences. [Reflective practice literature.]

Much has been written about nurses basing their practice on research being more cost effective and improving patient outcomes. If nurses are not research minded, how might they be encouraged to consume and participate in research? [Literature on research based practice.] I wonder whether the type of nurse who is a clinician is more interested in 'doing' and learning from experience rather than the type of nurse who is interested in research. [Personality types in different professions literature.]

In order to base clinical nursing practice on research, studies need to be measurement based so as to prove one way of nursing to be more beneficial than another. Research studies which highlight experience and meaning would be consumed more on an individual basis to give nurses understanding and insight into their practice. [Research based practice literature.]

There is an argument for practitioner based action research as a political move where practitioners' involvement in reflection about practice allows for more responsibility in decision making. This argument contradicts outside researchers making recommendations to practitioners which may be inappropriate when seen in context.

Theoretical learning plays a lesser role and it was evident that some things learned had been forgotten or were not able to be clearly articulated by the nurses. [Literature on formal learning - retention of knowledge.] The nurses suggested that they could improve their knowledge of pharmacology and physiology.

5.4.2.6 *The contents of the satchel*

While nurses use narcotic analgesia, sedation, positioning, hygiene, touch and talk in an effort to address the possibility of pain, they are also concerned about related issues such as narcotics being somehow harmful or sedation causing amnesia. [Pain therapy literature.]

5.4.2.7 *Accessing the satchel*

Doctors presently have the power to allow or restrict the administration of narcotics and sedation to patients. Although nurses may believe patients are in pain, doctors control the most effective pain relieving options available. [Doctor/nurse literature.]

5.4.2.8 Dispensing satchel contents

The care that nurses give is based on their interpretation of patients' pain and what they think would be of benefit, yet each nurse's perspective varies according to individual experiences and connection with patients.

Instructions on how to dispense satchel contents in the form of guidelines for assessment and management of pain in unresponsive patients could be based on available research, physiological and pharmacological knowledge and practice of those considered experts. Problems with this include: no available research on immediate patient experience, only memories, and the notion that experts' practice is hard to articulate. [Literature on expert practice being intuitive.] Guidelines would provide a standard for minimum care that would not invalidate nurses own assessment and management skills, but would be a resource especially for novice and beginning practitioners who do not have their own experience to fall back on. Guidelines would also give confidence to nurses in the face of opposition from doctors.

I wondered about the acceptance of guidelines by the nurses. I think the nurses would see the guidelines as a restriction to their autonomy as nursing professionals, although the unit has protocols for many practices already. Maybe it would depend on the level of development of the practitioner as to the usefulness of the guidelines. If the aim of introducing guidelines was to ensure a minimum standard of care, then how would patients' outcomes be measured? How would the impact of nurse individuality be measured? I assumed that consistent care is better than varying care.

Table 5.4.1 depicts a summary of my perception of advantages of introducing guidelines for consistency of pain care in unresponsive patients by contrasting current nursing practice with the ideals of the profession.

Table 5.4.1 Viability of pain care guidelines

Now - reality	Ideal - rhetoric of profession
Variable assessment based on nurse characteristics - knowledge level, previous nursing experience, personal experience	Assessment guidelines to ensure closest possible guess of pain/comfort level by all nurses
Variable management based on nurses' assessment, pharmacological knowledge, physiological knowledge, previous experience with therapies, Doctors orders.	Management guidelines to ensure minimum adequate management of pain and provision of comfort
The nurses experience uncertainty and cannot evaluate their care	Nurses could be sure that their care was at least at the minimum required, based on the best knowledge available

5.4.2.9 Lighting the room

A long term possibility of scientific research findings which would increase knowledge on what these patients were actually experiencing while unresponsive could include a quantitative measure of comfort/pain such as:

1. statistically averaging awake patients' experiences of similar pathophysiology
2. measuring endorphins
3. measuring neurological or chemical transmission in the 'pain centre'

This research has highlighted a nursing situation where care given heavily relies on the characteristics of the nurses and patients in this relationship. There is potential for a lot of variability. If consistent care of patients would improve outcome, then further research needs to be done to provide the information on which to base care guidelines that would ensure a more consistent level of care without discrediting what nurses can 'see' and 'do'. Implementing guidelines would not eliminate the need for nurses to be vigilant for the detection of any anomalies. Guidelines would need constant revision and updating.

Another option which would help address any inconsistency would be primary nursing - rearranging the allocation of nursing staff to the care of these patients so that there would be a consistent team of carers for each patient.

5.4.3 About choosing key issues to discuss

The aim of moving away from the metaphor format was to provide depth of thought on the major issues that I wanted to highlight rather than present a descriptive discussion that was thinly spread over all the information from participants. Even though the present format of this thesis is not organised around the metaphor, the visual image has continued to guide my thinking throughout writing. At this juncture I wanted to try and pull out the issues that I saw in the collective story and show their relationship with each other then explain why I had chosen some for the discussion. My aim was to suggest ways forward for all issues. I settled on the issues of uncertainty, connection/disconnection, experience/knowledge, and constraints. I depicted the relationship between the issues as follows in Figure 5.4.3:

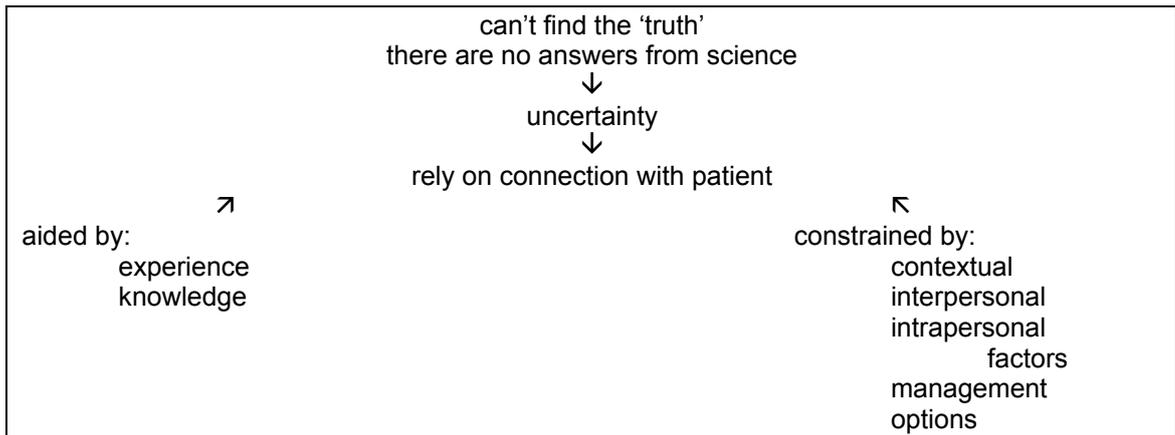


Figure 5.4.3 Relationship between issues

Searching for ways to explore each of these issues and relationships between issues is presented in Table 5.4.2 in terms of systematically stepping down through Figure 5.4.3. My questioning is located in italics.

Table 5.4.2 Exploration of key issues for discussion

Because we cannot measure the experience of comfort or pain in these patients, we are uncertain as to their experience.	<i>The issue of measurement, quantifiability and generalisability versus individuality of experience.</i>
Nursing has accepted that there is individuality among patient experiences. Subsequently, nurses have been advised to listen to what each patient says about their pain experience, but that does not help us. These patients cannot tell us what they feel and other physiological and behavioural signs of discomfort or pain can be blurred by their extreme illness, so we are left uncertain of their experience.	<i>The issue is whether it is OK to be so uncertain in nursing and how do we cope with it? (Does this have to do with quality of nursing practice? Do I need to delve into the psychological literature? Does it depend on how much anxiety it produces - does that amount of anxiety depend on your view of nursing - whether uncertainty is acceptable or not?)</i>
From our collective story, uncertainty (or anxiety) was relieved somewhat if we were able to achieve a level of connection with or disconnection from the patient. There seemed to be a continuum from connectedness to disconnectedness. Achieving connection resulted in satisfaction (coping with uncertainty/anxiety). Disconnection was a defensive way of coping with uncertainty.	<i>The issue is coping in nursing - we are humans and not necessarily able to give fully and continually in all situations in an angelic way. (We need to look after our own mental health) Also, whether it is possible to have a relationship with a non-responsive patient which you would call connection. (Some literature suggests it is not possible)</i>
Mechanisms of disconnection: Doing tasks	<i>The issue of routines in nursing, lists of jobs to do for the shift, not enough time to do them. (literature suggests this is how less experienced nurses cope)</i>
Prioritising recovery	<i>The issue of management options for pain limited in some critically ill patients and our assumption that the patient wants to live.</i>

Table 5.4.2 Exploration of key issues for discussion (continued)

Mechanisms of connection:	<i>The issue here is that in the face of unavailability of subjective data, what do we turn to? We can't measure - can we generalise? On what basis do we generalise? Using what information? How do we apply the general to this particular patient? How do we individualise our care?</i>	
'Know' pathophysiology	<i>The issue of different levels of education among the nurses (general certificate, ICU certificate, post graduate work) each course has different content. Large amount of beginners. High turnover. Complexity of interrelated pathophysiologies and the need to prioritise. (This may cause nurses to stay novices for longer, coping by doing tasks) Pain mechanisms not thoroughly understood anyway. (Generalising)</i>	
Link to similar experiences - nurses' personal or close family	<i>Obviously different personal experiences impact on what the nurse brings to this relationship. (Can move both ways to connect or disconnect) Leads to variation among nurses. Issue of minimum standard in care. (Generalising).</i>	
- previous patients	<i>Nurses have looked after different patients and this previous input affects this relationship. How can this learning through experience be shared? (Generalising)</i>	
'Know' person of patient - relatives	<i>Issue of how not liking the patient's family affects your care of the patient. Getting the family's view on the patient. (Starting to find the individual, because there are still many views within one family)</i>	
- contact time	<i>Finding out this person's idiosyncrasies. (Individualising) The worthwhileness of contact time to connection depends on individual nurse's commitment and ability to observe with a desire to be connected. (The issue is what we think our role is - comfortable patient = good nurse)our contact time generically as nurses is greater than doctors, but on an individual level may not be, however, we think we have a better connection than doctors.</i>	
Our collective story showed that even though we may have felt connected, there were constraints that we felt hindered our care.	<i>Issue of coping with frustration - working with your hands tied</i>	
- interpersonal relationship with medical staff	<i>Doctors order nurses advocate</i>	
- pain management options	<i>If you get rid of all the pain, you're dead</i>	
- lack of alternative comfort options	<i>The unit allows a narrows range of options, and does not tolerate alternatives.</i>	
- no continuity of contact time (controlled by the manager's way of assigning patients - and also backed up by majority of nursing staff who would not like to be 'stuck' with one patient and see them through)	<i>Issue of allocation of patient assignments - random/according to level of expertise/avoid getting 'involved'</i>	

5.4.4 About stories and counter-stories

The next shift in my focus resulted from being immersed in storytelling as process. I imagined that issues might also be presented in terms of 'story'. At the same time finding the tension of opposing notions within this study led me to consider discussing the dichotomies of 'doctor/nurse', 'distant/close' and 'pain/dead'.

When conceptualising comfort and pain in ICU I thought of them on either end of a continuum, however, the process of analysis of words, teasing out meaning, brought out the complexity surrounding notions of pain and comfort. Placing opposing ideas against one another can bring to light what we are dealing with but it may not be helpful to leave the situation thinking that the only options are the opposing extremes. Living within the complexity and accepting the fluidity of our existence we can shift and influence change. We don't have to continue working in dichotomies which force us to extremes. Understanding, communication and community can enable us to provide more consistent and appropriate care for patients in a way that is safe for us by protecting our psyche.

The three opposing notions that are present in our day-to-day work, the notion of patients being 'in pain' or 'dead', the notion of 'closeness' and 'distance' in our relationships with these patients, and the notion of opposition in the relationship between nurses and doctors. For each dichotomy or area of tension, I explored the opposing positions and their pull then hoped to find a space where we could be comfortably located between the two extremes. I was moving from dichotomy to complexity and fluidity.

Coping with the uncertainty permeates all aspects of this nursing situation. Nurses can be uncertain as to whether these patients are experiencing pain, how much pain patients would be prepared to undergo in order to recover, or in fact whether they want to recover or would prefer to die. Nurse can be uncertain of their relationship with doctors: some fearing doctors' status or the intimidation they sometimes deal out, other nurses not wanting to rock the boat keep their opinions to themselves. Nurses can also be uncertain of the goal of care. Although nurses aspire to relate to patients in a close way, they may be uncertain of the cost to their psyche when expected to be more than human.

Discussing these dichotomies shows further complexity as each extreme position can sometimes be viewed as good and at other times bad – or a desirable or undesirable state. Table 5.4.3 is my perception of the contrasting alternate good and bad extreme positions in each of the dichotomies.

Table 5.4.3 The good/bad dichotomy

GOOD		BAD
Doctors (they know and can see more than nurses)	<i>But nurses live in the 'in-between' space</i>	Nurses (lowly, subordinate, less knowledge)
Nurses (more holistic view, more caring)		Doctors (more focussed on recovery at all costs)
Dead (suffering is ended, peace at last)		Pain (living torture for what outcome?)
Pain (protects and motivates)		Dead (life is valuable)
Close (helps us gain more knowledge for assessment and motivates caring actions)		Distant (overlook the person of the patient)
Distant (protects our psyche from disintegration)		Close (focus becomes narrow, lose sight of wider picture, decisions made on emotional basis)

The take home message is that we are not alone in all of this complexity and all we need to do is our best. Understanding the knowledge base of our decisions, communicating our perceptions and insights with other health professionals and contributing to, as well as being supported by, the community of the work environment will lead to better nursing care of pain in unresponsive patients.

5.4.5 About the context, characters and action of the story

I moved away from the taking of extreme positions to make a point and I aimed to appear less provocative. However, I still wanted to use storytelling structure in presenting issues for discussion. Hence, I framed my thoughts in terms of the Labov and Waletzky elements of a story: context, characters and action. Underlying this format was the concept of nurses imagining themselves in the place of patients expressed as the phrase, 'put yourself there'. The imagery of spotlighting reflects the metaphor of shedding light relating to new knowledge around each of the concepts held within 'put yourself there'.

5.4.5.1 Spotlight on the setting - 'there' - where the action takes place

Presenting information about the context that surrounded and impacted on the situation of ICU nurses dealing with the possibility of pain would facilitate nurses' awareness. I wanted nurses to be cognisant of and thus be in a position to understand that taking measures towards making the environment work for them could positively impact on how they dealt with patients' pain.

The following points cover the information provided by participants in regard to the setting in terms of nursing movements and interactions, the direction of patient care, the lack of objectiveness around pain and the high-tech physical space.

1. Making plain how the people normally function together in the unit
 - (a) The current unit routines
 - (b) How nurses relate to other health workers
2. Showing the tension between recovery versus comfort as the aim of patient care
 - (a) The impact on nurses of withholding analgesia to enhance progression towards recovery
 - (b) How nurses respond to untreated pain
 - (c) How nurses respond to inflicting pain
3. Explaining why nurses cannot know for sure what discomfort or pain the patients feel
 - (a) Pain cannot be measured when patients are unconscious
 - (b) Nurses ideas for measurement possibilities
4. Describing the uncomfortable interface between patient and physical environment through connections to technology, noise, cold and light
 - (a) What patients remember about:
 - ICU environment
 - Treatment procedures
 - (b) The fact that not all patients report memories
 - (c) Significance placed on discrete memories versus diffuse feelings
 - (d) The suggestion of bringing patients back to talk to nurses

5.4.5.2 Spotlight on the patient - 'there' - the silent character

Presenting the participants' views on elements that can be known, as well as assumptions nurses carry regarding unresponsive patients, results in more questions. If nurses 'put themselves there' in order to imagine what it is like for patients, where is 'there'? If the patient is lying still the nurse might think that 'there' is comfortable

whereas the real 'there' may be painful. Sometimes doctors think 'there' is a different place to the nurses.

The following points reveal the information provided by participants in regard to the patient in terms of nursing beliefs about pain, the meaning of visual cues of comfort and the impact on pain care of nurses interacting with relatives.

1. Nurses' folklore of pain
 - (a) Ranking the painfulness of conditions and procedures
 - (b) Thinking that withholding analgesia causes patients to feel more pain
 - (c) Dead patients feel no pain
2. The meaning attributed by nurses to what patients look like
 - (a) Calm patients are comfortable
 - (b) Good nurses are able to make their patient look comfortable
 - (c) The paradox of possible pain in calm patients
3. Interacting with relatives affects pain care by nurses
 - (a) Relatives can direct nurses' focus onto patients' comfort
 - (b) Relatives' needs can divert nurses' time and attention away from the patient

5.4.5.3 Spotlight on the nurse - 'yourself' - the leading character

Presenting information about how the participants viewed themselves in the role of 'nurse' and what they brought to the encounter with patients' pain experiences raises awareness of professional and individual elements of pain care. There is variance between nurses through education and experience of patients. There is variance within nurses over time though tiredness or levels of available emotional energy. Nurses' 'yourself' is different to doctors' 'yourself' because of doctor's focus on patient recovery from a belief of scientific training. Nurses think the doctors' 'yourself' is more important.

The following points uncover the information provided by participants in regard to themselves as nurses. Specifically, participants referred to the impact on pain care of what they believed to be their professional role, their experience and knowledge and their personal internal resources.

1. Nurses' beliefs about their professional role
 - (a) Tension between the doctors' priority of patient recovery and nurses' priority of comfort as goals of care
 - (b) Finding patient comfort to be one measurement, assessment or judgment of a 'good' nurse

- (c) Feeling the need to advocate for patients
- (d) Desiring more autonomy
- 2. Nursing experience and knowledge needed
 - (a) The extent of patients and medical conditions encountered during nursing
 - (b) Understanding of and experience with pain treatment options
- 3. Personal capacity within nurses
 - (a) Coping with working within uncertainty
 - (b) Personal confidence level
- 4. Personal needs of nurses
 - (a) Tiredness directs focus away from patients
 - (b) Stress inhibits clear thinking

5.4.5.4 Spotlight the action - 'put' - seeing then balancing

Presenting information about the participants' actions towards relief of pain enables clinical knowledge to emerge. Neither assessment nor management of pain are simple, rather, each has limiting and facilitating factors that originate in the setting, patients or nurses. For example, being able to 'put' is constrained by being judged as a 'good nurse' by other nurses, based on whether your patient is lying still and looking neat. Nurses seem to have more time to 'put' than doctors.

The following points reveal the information provided by participants in regards to the action of assessing and managing pain. Specifically, participants referred to the way they 'see' pain, options they implement to reduce pain, how pain care must be balanced with the priority of patient recovery and the awful possibility of patients appearing to be comfortable but actually in significant pain.

- 1. Ways nurses assess pain - 'seeing'
 - (a) Degree of connection with patients relates to what pain cues can be seen
 - (b) Minimising of pain through hardening of nurses or purposeful reduction of patient anxiety
 - (c) 'Spectacles' - factors that help nurses to see more clearly
 - (d) 'Sun glasses' - factors that blur nurses' vision
- 2. Available pain care options
 - (a) Medication – analgesia and sedation
 - (b) Nursing care – communicating with patients and handling their body
 - (c) Alternative therapy – outside nursing
- 3. Balancing effort towards opposing priorities of comfort and recovery
- 4. Paradox of the appearance of comfort if patients are in pain is a tragedy

After nurses have ‘put yourself there’ they have to communicate with doctors.

Each step of the process of trying to structure the discussion added depth to my thinking.

5.4.6 About coloured spheres of interactions

Next my focus moved to the interrelatedness of the people involved and the impact of relationships on the actual process of pain assessment and management.

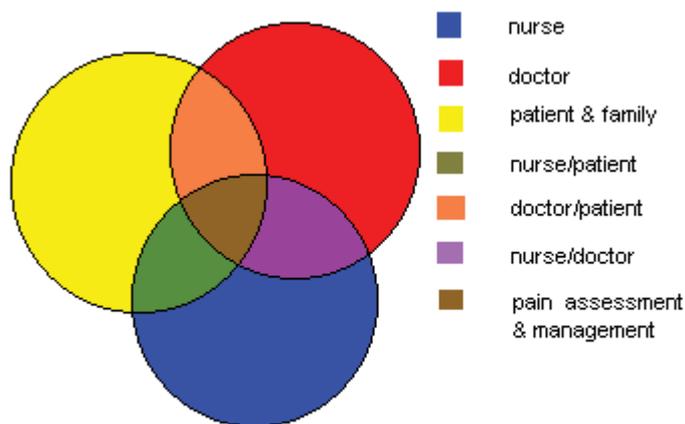


Figure 5.4.4 Coloured spheres of interactions

Depicting the whole scenario of assessing and managing possible pain experienced by unresponsive patients in ICU as overlapping spheres, as shown in Figure 5.4.4, allowed me to use visualisation to better understand processes at play in this situation. I chose to use the three primary colours to represent the life-worlds of the three main characters, yellow for patients and their families, red for doctors and blue for nurses. These result in the overlaps being three other distinct colours, orange for the doctor/patient and family interaction, green for the nurse/patient and family interaction and purple for doctor/nurse interaction. The murky brown colour at the intersection of all three spheres represents a mixture of the three primary colours and a place where all three characters are located at the point of considering pain.

'Being' in the life-world, as depicted by the sphere, is not a static state but rather dynamic in that we move about within the sphere and the sphere makes contact with other spheres using different parts of the surface. Acknowledging that storytelling and listening shape ourselves and our life-worlds allows me to use the snapshot stories [anecdotes] given to me by my colleagues to look at factors which motivate us to move within our life-world or present different surfaces of our spheres for interacting.

Interactions between spheres involve initiation, aspect, depth and temporality as depicted in Table 5.4.4. Understanding the contents of spheres leads to seeing motivations for or against contact.

Table 5.4.4 Exploring interaction between spheres

Initiation	Who moves towards/away from whom
Aspect	Which part of the sphere is being contacted
Depth	The significance/meaning of the contact
Temporality	Duration or the length of time of the contact as well as history and anticipation - placement in past/present/future.

Where the spheres collide and overlap, the complexity of each confronts or compliments the other. As overlapping occurs, each sphere's colour is affected by the interaction. Getting a clearer picture of the nurses' sphere and the overlap with spheres of doctors, and patients with their families, helps us to better understand our sphere and thus be less haphazard and more thoughtful in each interaction. Becoming aware of these processes may enable us to be more empathetic of others' life-worlds, having respectful dealings with others and be more able to cope with the demands of our work.

I thought that tracking via colour-coding would aid in keeping the 'bigger picture' in mind as I discussed what each sphere and interaction represented.

5.4.6.1 Blue sphere – the world of nurses

From the participants' perspectives, I gleaned aspects of the world of nurses. Nurses bring their individual selves with varying levels of energy, emotion, cognition and skill and relate to each other on varying levels such as collegial, teaching, managing and role modelling. The nursing profession imposes expectations, norms and rules. Inside the world of nurses there is the status of trustworthiness but subservience and the goal of practice being care focussed. Nurses place value on the whole person of patients

and claim their care to be holistic. Especially, pain should be treated, avoided or dealt with in some manner.

5.4.6.2 Red sphere – the world of doctors

Looking from the outside, the participants gave their perspective on the world of doctors. Participants saw doctors having power to make important decisions and status in the form of respect – the nurses thought doctors may believe they are omnipotent or omniscient but these beliefs come with a price when fallible. Believing the goal of medicine is to cure or bring about patient recovery, person of patient may be lost by doctors when focussing on pathophysiology or valuing case knowledge. Nurses thought doctors held a view that pain may be a necessity.

5.4.6.3 Yellow sphere – the world of the patient and family

The world of patient and family as observed by participants involved understanding the patient and family are in crisis – displaced from their normal social context and disrupted from normal functioning. Nurses are unable to access patients' personhood because of unresponsive state. For patients near death, it may be unknown if they want rescue, they are probably in pain, it is unknown how much pain they are willing to endure for the sake of recovery. Participants noted that families focus on eliminating pain.

5.4.6.4 Purple intersection – doctors (red) and nurses (blue) interacting

Participants referred to the doctor/nurse interaction in similar terms as the doctor/nurse game by Stein (1967) – a classic work which describes ways the two professions have interacted over time.

5.4.6.5 Orange intersection – doctors (red) and patients (yellow)

Participants referred to the doctor/patient interaction where doctors value professional distance in interpersonal relationships yet have continuity in contact with patients over their length of stay in ICU. This interaction can be contrived by nurses making patients ready for doctors to see them.

5.4.6.6 Green intersection – nurses (blue) and patients and family (yellow)

Participants referred to the nurse/patient and family interaction in terms of nurses having control over space and time but the relationship having varying levels of closeness or distance. There is continuity in the nurse/patient and family interaction over a shift but nurses have changeable patient allocations. For one shift nurses see all situations patients experience, such as repositioning and suction procedures, but may

not have worked with this patient before and may not again for a while. Nurses' connection with patients is influenced by attractiveness of patient and family whether nurses like, dislike or are intimidated by them. Nurses chose the involvement level of family in patients care.

5.4.6.7 Brown murk – considering pain

Participants included elements from themselves, doctors, patients and family as well as how each interacts when considering pain in unresponsive patients.

I aimed to make the spheres and intersections transparent, that is more easy to see within, so that we can each know what is going on for each other so that we may work together more as a community, having respect for each other and moving towards a mutually agreed upon end point.

Representing interactions between '**individuals**' in different roles as spheres touching, bumping, or colliding can help us to visualise what is brought to the encounter and how each person may present themselves differently at different times and to different people.

Representing interactions between different '**groups**' as spheres touching, bumping, or colliding can help us to visualise what is brought to the encounter and how each group may present themselves differently at different times and to different other groups. Are groups more stable than individuals? But groups are made of individuals and really groups do not contact each other as whole groups but as individuals representing the groups that they belong to; even the literature of a group is a collection of ideas and writings of individuals.

Understanding what is contained within spheres can help '**individuals**' to understand themselves as well as seeing more of what is inside others' spheres and thus having empathy and understanding of others' points of view and decisions.

Understanding what is contained within spheres can help '**groups**' to understand themselves as well as seeing more of what is inside other group's spheres and thus having empathy and understanding of other groups' points of view and decisions.

Understanding the nature of the contact between spheres can enable **'individuals'** to make more considered decisions rather than spontaneous reactions towards each other.

Understanding the nature of the contact between spheres can enable **'groups'** to make more considered decisions rather than spontaneous reactions towards each other.

In the end I am a nurse and this is nursing research and so I am not addressing patients, their families or doctors explicitly, rather, I hope a positive outcome of my research will involve individual nurses gaining a clearer understanding of the contents of spheres and the forces involved in spheres contacting. I also hope that this clearer understanding will allow nurses to speak up for themselves and patients in a way that can be heard yet showing respect when contacting other spheres.

Not knowing pain experiences of patients in our care creates a working environment of uncertainty which adds to the already stressful nature of nursing in ICU. Having no way of finding certainty in our pain assessment of these patients, we need to reduce other areas of uncertainty and stress in order to make the total stressful load lighter to bear. Using connection to cope motivates nurses to try to see better what is going on for the patient using their own eyes as well as looking from other's viewpoints. Using distancing to cope means that nurses look away from patients' experiences focussing instead on patients' recovery or their performance as nurses or their personal needs.

Better understanding the life-worlds of our main story characters, patients and their family, nurses and doctors, can be achieved by imagining each **'individual'** or **'group'** as a sphere.

5.4.7 About 'seeing', 'doing' and 'coping' in an environment of uncertainty

The next change of focus was to incorporate elements of the nursing process, 'seeing' and 'doing', together with the key elements of 'uncertainty' and 'coping' and explore them in relationship with each other. I devised Figure 5.4.5 in order to visualise the flow of interrelatedness of 'seeing', 'doing, and 'coping, within the environment of 'uncertainty' around unresponsive patients' pain.

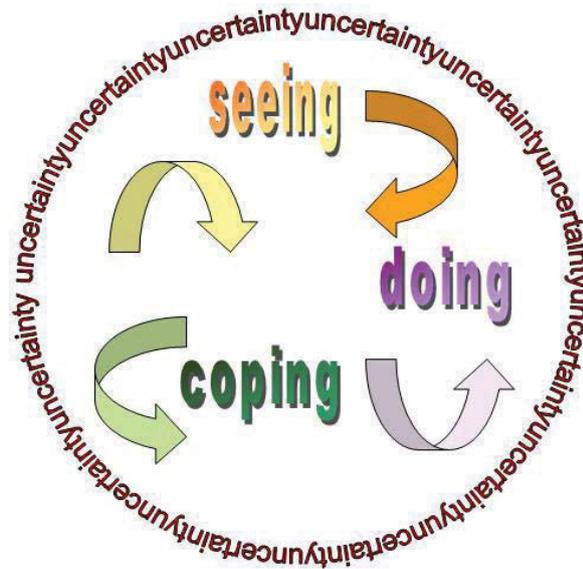


Figure 5.4.5 Seeing/doing/coping in uncertainty

It would be easy to hold the context responsible for creating this difficult situation – other professionals or the culture or the philosophy – it would be easy to point the finger at nurses for not knowing enough, not having enough experience or playing victim, it would be easy to criticise science for not finding us a measurement or something objective to go on, but nobody can know for sure unresponsive patients' experiences of comfort and pain and nothing can be done at the moment to let us know. I thought there would be a collective wisdom that I could tap into by listening to other nurses talk of their practice but there were no answers, rather a presentation of great complexity inherent in caring for comfort and pain in silent patients. While we cannot know the experience of these patients and others cannot know the experience either (ie doctors/relatives) then the described complexity surrounding this situation points to ways we cope in the face of uncertainty/awfulness/the possibility of torture. We have to believe that our practice is good or we dissolve.

We have to do something and so what do we act on? I have explicated the things that influence our assessment and management, but ultimately however much knowledge or experience we have we still don't know for sure what unresponsive patients experience.

The outcomes of this study are the actions nurses as a collective are aware of doing and the factors we are aware have influence on what we do. I did not find the answer to 'how do we know about patients' pain?' Nurses continue to be unsure of patients' pain

and it is not necessarily important to be 'sure' to improve pain care. The insights from this study show ways in which we help ourselves to think we are doing a good job. Some nurses think the more we know the better we will care for patients' pain while others are comfortable with not knowing for 'sure'. Some nurses tend to elevate the doctors' knowledge level and therefore take the medical assessment as right. One benefit to nurses in abdicating responsibility is to cover the possibility of their own assessment being wrong. Nurses may cope with the uncertainty of not being 'sure' by holding the notion that doctors are more important - so nurses do what doctors say.

The flow diagram Figure 5.4.6 on the following page offers a more complete word summary of the concepts alluded to in the previous intertwining diagram Figure 5.4.5.

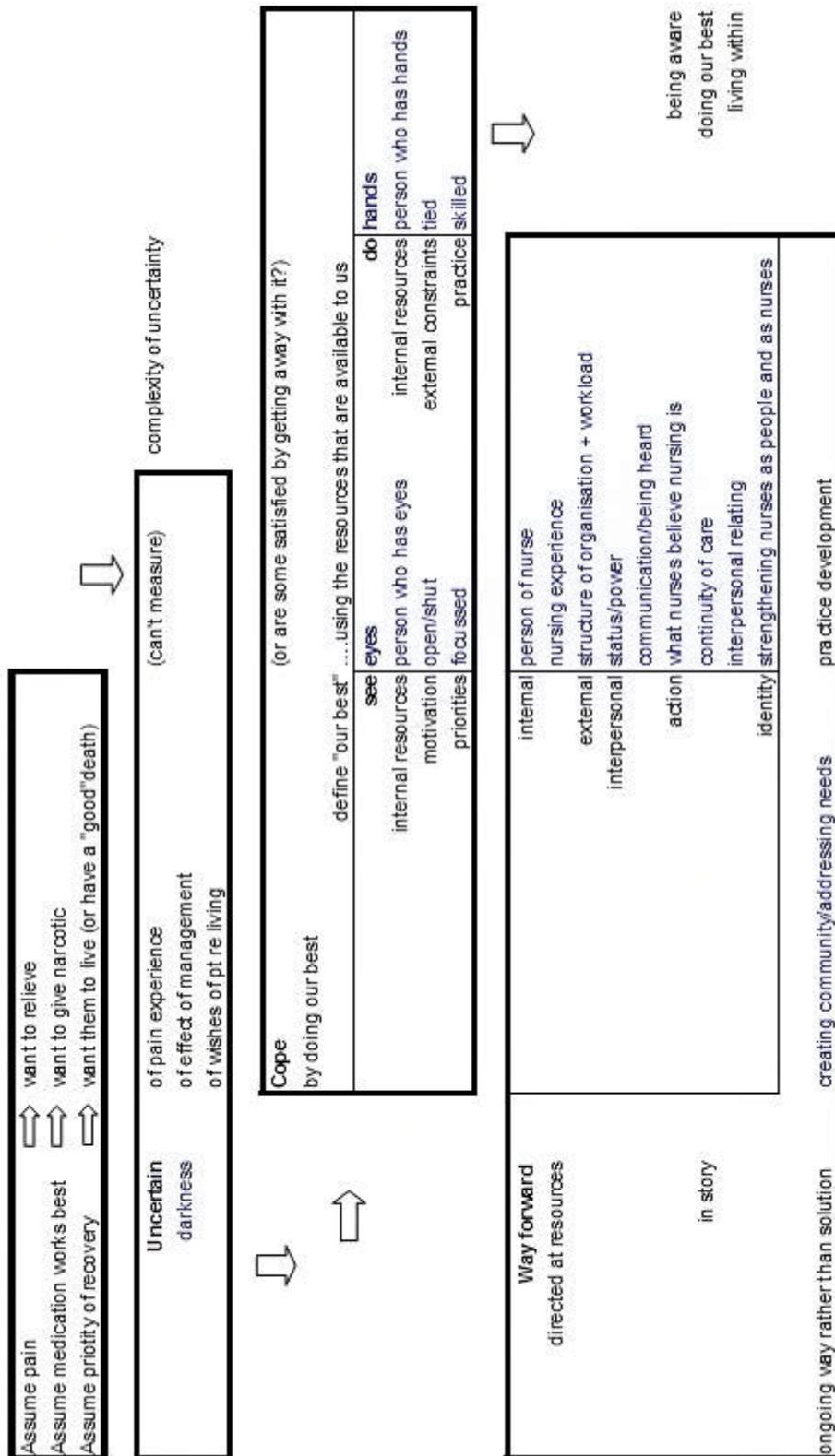


Figure 5.4.6 Flow diagram of issues

5.4.8 About uncertainty and coping

Next I used the concepts of epistemology and ontology to divide the issues into those about 'knowing' and others about 'being'. Ostensibly the discussion chapters have retained this format with the additions of current practice, in terms of pain assessment and management options, and storytelling. At this final stage of organising the presentation of discussion my focus turned to dialectics and synthesis.

There is something about ICU, pain and me that sparked my interest and provoked me to action. There is something about stories that rings true; that works. There is something about knowing and being that makes us who we are in a given space and time. There is something about telling that allows us to know and be in response.

Being a clinician writing academically makes for an interesting journey. Wanting to do justice to the depths of substance in the conversations I shared with my colleagues, as well as making my comments accessible to nurses working clinically, means that I walk a tightrope of language and semantics. Over the time spent on this study I have made several attempts to create meaningful ways of presenting the concepts that arose from this research. All of these conceptual ideas are present and form fragments of the discussion but the overall sense I wish to portray is that of 'head', 'heart' and 'voice', in the academic garb of epistemology, ontology and stories.

Remembering the constitutive and constituting nature of stories impacts on all three stances I wish to address.

The nature of 'head' and 'heart' provokes tensions to arise and it is in dealing with these tensions that we find the real courage and creativity of nurses. 'Voice' in both speaking and being heard links heads and hearts, 'knowledge' and 'being', epistemology and ontology. Coping equals a resolving of tensions between epistemology [head] and ontology [heart] – so then the concept of coping could be placed under story [voice] or separately. Coping can come about by a shift in epistemology or ontology and not be *voiced* or expressed. However, if we see story as constitutive, coping would involve congruence - so we change the story or live under a different story. The concept of coping can be included in the head section by talking about tensions that are intellectual, in the heart section by talking about tensions that are felt and in the story section by talking about living out congruence.

Organising the issues for discussion under the concepts of ‘head’, ‘heart’, and ‘voice’ and holding together the constitute/constitutive and expressive/explanatory dialectics whilst considering ways to move forward in terms of coping, led me to contemplate human psychological needs. If nurses’ psychological needs were being met would they then cope better with the difficulties and complexities inherent in working with pain in unresponsive patients? Indeed, would nurses go further than just ‘cope’ to be initiators of good outcomes? Once again my personal journey impacted my thinking at this juncture. Having attended an ‘Unleash the Power Within’ weekend by Anthony Robbins (2004), I found his description of ‘six human needs’, as portrayed in Table 5.4.5, to dovetail with my delineation of concepts of ‘head’, ‘heart’ and ‘voice’. Further to the fit between Robbins’ list and my work is the dialect nature of the pairs of needs. I perceived that satisfying these needs might flow into or out from individuals.

Table 5.4.5 Robbins’ six human needs in dialectic pairs

Into	Out from
Certainty	Uncertainty
Significance	Connection
Growth	Contribution

I see nurses’ needs for certainty and uncertainty to play out in the ‘head’ section in terms of ‘knowing’ or not ‘knowing’. The certainty of ‘knowing’ may be in response to clear information flowing into the individual. The uncertainty of not ‘knowing’ may be the flow from an individual in response to unclear information. The ‘heart’ section deals with nurses’ needs for significance and connection with reference to ‘being’. The state of ‘being’ significant may be externally evaluated flowing into an individual. The state of ‘being’ connected may flow out from an individual towards that to which they are connected. Finally, dealing with ‘voice’ relates to nurses’ needs for growth and contribution. Growing may occur in response to the flowing in of others’ ‘voices’. Contributing may involve an individual letting their ‘voice’ flow out.

I believe the flowing in or flowing out from an individual reflects the constitutive or constitute stances. Underlying the juxtaposition of these many dialectics is Hegel’s philosophy of thesis and antithesis leading to synthesis as previously explored in section 3.3.4.2.

5.4.9 About the final focus

I have decided to name the discussion chapters of this thesis 'synthesis' in keeping with the underlying Hegelian philosophy. Section 7.1 of the synthesis was formed soon after the collective story and resulted from my original question regarding nursing unresponsive patients' pain. I presented the answers of what we 'do' and what other ideas participants had in terms of assessing pain, pain treatments or comfort measures. Subtle pain cues, assumptions about pain, impact of patients' relatives and doctors, analgesia [especially morphine] and sedatives [especially midazolam], were the most discussed followed by touch, talk, hygiene, position and then the possibilities of music and aroma. Some comparison with literature on assessment and treatment shows possible benefits and issues to consider. Section 7.1 does not delve deeper than the concrete nursing actions.

The three remaining sections 7.2, 7.3 and 7.4 are more intertwined but need to be separated for thesis structure and delineating concepts. I have chosen to approach the deeper levels in terms of head, heart and voice. I think that the logic of this format comes from within me in that I searched for understanding [head], felt frustration [heart] and then communicated [voice]. These sections of the discussion also contain the professional rhetoric that is relevant to nursing unresponsive patients' pain. Skill acquisition, autonomy, advocacy, justice and concepts of care and comfort from the literature are perused in respect to participants' views.

5.4.9.1 Head (epistemology)

The following ideas are contained within the section on 'knowledge':

1. Why the 'how to' instruction on unresponsive patients' pain was unavailable - definitive measurement not yet found - providing scope for further research
2. My motivation for wanting such an instruction on 'how to'
3. The reasons nurses would want instruction on 'how to'
4. The reasons nurses would want to understand
5. Information from participants on the nature of knowledge
6. Information from participants on the nature of experience
7. Relationship of certainty/uncertainty with locus of control
8. Relationship of confidence to knowledge
9. Instruction is the lowest level of safe/competent care
10. Information is used to be informed/responsible/professional in decision making

11. Gut/intuition can be:
 - (a) expert [gestalt]
 - (b) variable [resources inside nurses vary]
 - (c) convenient [react rather than respond]
12. Having no idea/uncertainty can be:
 - (a) paralysing [stops action/uses up time/diverts focus from other care]
 - (b) unsafe. [notion of being prepared to avoid critical situations]
13. Informing clinical nurses on pain physiology and pharmacology
14. Gaining wider experience with different scenarios [time spent nursing versus what nurses encounter during that time]
15. Accessing patients' memories of pain experience as a guide.

My intention in terms of 'knowledge' was to ascertain the knowledge nurses valued and expressed and then make circumstances happen that would enable them to move forward in that knowledge.

I see the flow of logic regarding 'knowledge' to be as follows:

We cannot measure pain and therefore we cannot be accurate in assessment but we do know other information like: patient memories, nociception (tissue trauma, uncomfortable interface with technology), what pain we have felt, what pain we imagine, physical responses observed, usual practice, what the doctors tell us to do, expectations of relatives, folklore of dying being painful but death is the cessation of pain or assumption that calm patient equals good nurse.

Tensions come from a 'need to know' expectation:

1. from self
 - (a) control
 - (b) want things pinned down
 - (c) lacking when required to teach others
 - (d) insecure & want reassurance
2. from relatives
 - (a) measuring standard of care
 - (b) want loved ones not to suffer.

If we had guidelines, the tension would be about restriction of autonomy. Tensions play out in the "heart" area in terms of feeling inadequate, at a loss and frustrated.

Coping measures located within the 'knowledge' area include:

1. trying hard to 'know for sure'
2. assuming.

5.4.9.2 Heart (ontology)

The following ideas are contained within the section on 'being':

1. Emotional responses in nurses to the disparity between wanting certainty that is unattainable and deciding to take action include feeling;
 - (a) inadequate
 - (b) unsure
 - (c) not confident
 - (d) unfocussed
 - (e) at a loss
 - (f) helpless
 - (g) frustrated.
2. Conversely these negative emotions would not be felt by those nurses who are comfortable with not knowing for sure and do not need certainty.

My intention in terms of 'being' was to ascertain how nurses felt and what strategies they used to keep their emotional equilibrium. I believed that finding what was best for nurses would ensure that in the course of nurses doing their job what was best for patients would happen.

I see the flow of logic regarding 'being' to be as follows:

1. We have patient comfort as a goal of nursing and we identify ourselves as the health carers whose role it is to provide comfort
2. We may relinquish the comfort role for cure in ICU
3. We identify ourselves as patient advocates
4. We may feel under-skilled to provide comfort
5. We may feel under-resourced to treat pain
6. The conditions we work within affect how we do the comforting role [shiftwork, unit policies, routines]
7. Our interaction with patients affects how we look after them.

Tensions come from the interactions with other health professionals who sometimes do not respond to our being comforters, advocates or even having the ability to assess

pain professionally. Tensions play out in the ‘voice’ area in terms of communicating or leaving words unsaid.

Coping measures located within the ‘being’ area include:

1. Reducing the need for certainty
2. Understanding complexity
3. Understanding impossibility of certainty of pain assessment
4. Nurses valuing their assessments
5. Nurses valuing the impact of their care on patients
6. Accepting the need for pain in some circumstances (for good in the end),
7. Nurses believing they are doing their best.

I wondered what would be the manifestation of nurses not coping.

5.4.9.3 Voice (story)

The following ideas are contained within the section on ‘communication’:

1. There are different genres of communication appropriate to different types of information
2. Telling stories is one way to communicate
3. Stories are told during basic nursing education, clinical learning, professional development
4. Individual stories are credible, believable and memorable and thus can have an emotional pull, for example, the media news, charities eliciting donations through telling the story of one child, theatre/drama/novels, preachers using anecdotes for sermon illustrations or tribes telling stories down the generations
5. Stories hold the availability of complexity and nuances and time (past/present/future)
6. Stories guard against the tendency to reduce life into simplistic formulas

My intention in terms of ‘communication’ was to get nurses to value what they already do when telling each other stories of their work. A formalising of storytelling may bring some balance to the evidence base of nursing care. In situations where measurement is not possible, clinicians’ storytelling allows insight into the complexity that is nursing.

I see the flow of logic regarding ‘communication’ to be as follows:

1. nurses giving voice to their knowledge
2. nurses giving voice to their feelings
3. nurses currently using stories to debrief with each other
4. stories could be used to share situated clinical knowledge.

Tensions in the ‘communication’ area include:

1. Nurses need courage to speak
2. Different meaning may be attributed to words
3. Nurses need space to speak
4. Nurses need respect to be heard.

Coping measures located within the ‘communication’ area include:

1. What is voiced comes back to the ‘head’ area in terms of knowledge
2. The act of saying helps the ‘heart’ area in terms of getting it out and being heard.

5.4.9.4 *What difference does this study make?*

After discussing dilemmas and coping strategies as well as types of knowledge and learning, what difference will it make for clinicians? How is professional development making a difference now? What is the interface between academia and nurses at the bedside? My intent is to demonstrate the worthiness of accessing storytelling as a valuable opening into the complexity of nursing and to provide the information obtained through the narrative approach of this study in a clinically friendly and usable way.

5.4.10 Summary

Section 5.4 has presented the progression of thought and format options that I considered over the long candidature. Complexity is apparent in increasing measure. The challenge was to present the complexity in a manner that was understandable but not so broken down as to make it simplistic and thus lose the understanding of the interweaving elements. Moving from a metaphor based discussion format through various visual attempts to an arrangement of thoughts based on ‘head’, ‘heart’ and ‘voice’ also moved the thesis impact from descriptive to explanatory and expressive.

This final explanatory section of the findings from this study contains the overview that provides the groundwork for the following sections 7.1, 7.2, 7.3 and 7.4 that represent the synthesis of the work. In the synthesis I want to bring more ‘certainty’ into the nursing response by opening up what is in the people involved and the processes of

nursing unresponsive patients' pain. I want nurses to have less overall 'uncertainty' to deal with even though they will probably always be uncertain of the pain experience of unresponsive patients. Understanding may facilitate nurses to consider the part they play and thereby choose to be thoughtfully responsive rather than just letting circumstances and reactions happen. Chapter 7 covers the topics of: section 7.1 presenting practice current at the time of interviewing in my unit, section 7.2 how nurses know and learn, section 7.3 coping with working in uncertainty, and section 7.4 the way to 'voice' effectively.

We have been on an epic journey and yet we are only half way to the destination. Right now we need a break. The interlude in Chapter 6 offers reflection on what has been covered so far and preparation for the conceptual innovation of the synthesis detailed in Chapter 7. The gift of the interlude is the visual aligning of dialectic concepts in a way that makes the complex interrelatedness apparent yet understandable. Enjoy!

Chapter 6: Interlude

6.1 Pausing - *linking the concepts*

To begin the interlude, I will share a reflective poem about the findings of the thesis that I wrote in the wee small hours one night duty:

There is nothing new – just a different way of looking at it.
 An unknown quantity
 Feeling unease
 Wanting to know
 The disquiet providing the momentum
 An inquiry
 Soaking up the information
 Looking at it from different angles
 Head and heart
 The distractions of life prolonging the search
 No answers
 Just insights
 We're doing ok
 Seeing into each other's worlds may help us do better
 So the words I put down draw the picture for you to see
 -Nerilee-

The poem portrays my disappointment on realising that at this time finding a way for nurses to 'know' the pain experience of unresponsive patients was not possible. I reflected on the motivation for me to undertake this study and how the knowledge gained has opened up a complex understanding of our common difficulties. Nurses handled the complexity but I hoped that sharing the expressive pieces, as well as my explanation in the thesis, would engender in them a higher confidence, a deeper belief in their value and a realisation that we are in this together.

The interlude is designed to take a pause in order to reflect on the processes undertaken in this study, in terms of methodology and method, as well as the thoughts and ideas generated from those processes presented in the findings. The pause also provides space to prepare for the intertwining of dialectic concepts, as represented in Figure 6.1.1 below, depicting the life-world of nurses: epistemological ['knowing'/head], ontological ['being'/heart], psychological [the six human needs] and narrative

[constitutive/constitute] as interrelated sets of concepts are given ‘voice’. A further narrative dialectic [explanatory/expressive] describes the way these concepts are given ‘voice’. I define ‘voice’ as either giving or receiving some form of communication.

The intertwining of these concepts and issues raised by participants continues in the following sections of synthesis. But for now, I have created an ‘expressive’ visual moment in the schematic linking of the sets of concepts from the study.

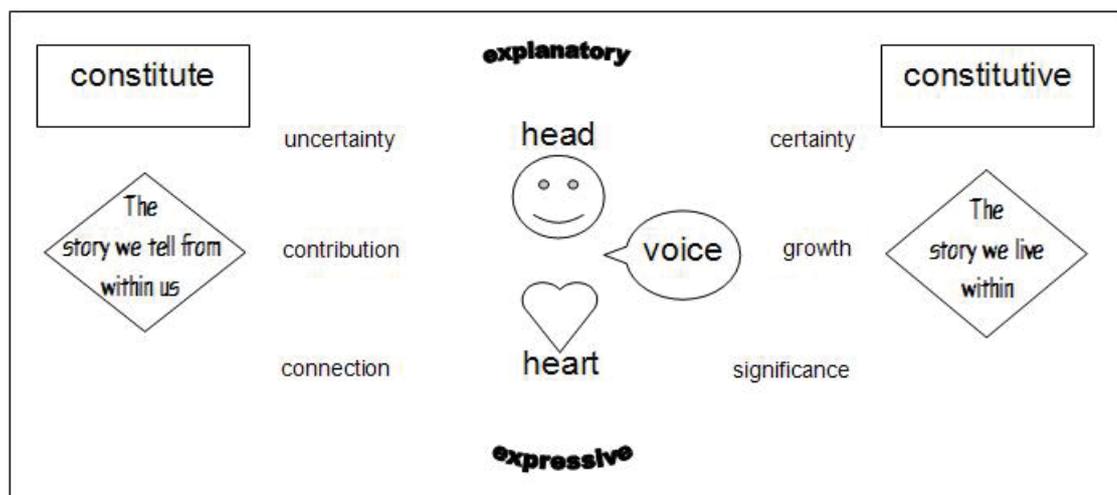


Figure 6.1.1 A dialectical narrative situatedness schema

6.1.1 The layout of concepts

The following ‘explanatory’ paragraphs about the schematic diagram in Figure 6.1.1 approach the concepts in a right-to-left direction which opposes the flow of reading in English and therefore I offer a reason for the layout of the diagram. I created the visual orientation of the diagram as a representation from my understanding of the place of each concept. Starting with a schematic person, the ‘head’ is above the ‘heart’ and the ‘voice’ comes from both so I situated ‘voice’ between ‘head’ and ‘heart’ but to the right as it was contained within a speech bubble. I intentionally placed ‘constitutive’ to the right as ‘voice’ interacts with the external. By default then ‘constitute’ was placed to the left. I aligned ‘head’ with ‘explanatory’ and ‘heart’ with ‘expressive’. The six human needs were placed according to their linkage with ‘head’, ‘heart’ or ‘voice’ and also in relation to ‘constitutive’ or ‘constitute’.

The concepts of ‘head’, ‘heart’ and ‘voice’ mirror my journey through the research process. From the impetus of experiencing a discrepancy between the expectations

and the reality of my practice in nursing unresponsive patients' pain, to pursuing information [head] in order to eliminate the tension I felt and then feeling frustrated [heart] at not readily finding an easy solution led me to speak, listen and write [voice].

The resulting thesis contains findings on the opposing elements:

1. living within expectations or 'being told' [constitutive] versus the experience that comes out from within us or 'telling' [constitute]
2. 'knowing' [head] versus 'being' [heart]
3. explaining versus expressing [voice].

I further aligned the six human need dyads:

1. uncertainty versus certainty with 'knowing' [head]
2. contribution versus growth with communicating [voice]
3. connection versus significance with 'being' [heart].

This thesis holds the complexity of these dichotomies within the medium of narrative.

6.1.1.1 *Dialectic to synthesis via dialogue*

I have relied on Hegel's dialectical philosophy to inform the linking of disparate concepts within this study. For Hegel, understanding is gained through a dialogue between seeming opposites, looking at opposing ideas in order to come to a new understanding that synthesises both.

Reason and Hawkins' description of explanatory and expressive paths of inquiry demarcates opposing methods of research. I am defining Reason and Hawkins' opposing paths as a dialectic. This study attains a synthesis of Reason and Hawkins' ideas because it comprises both explanation [head] and expression [heart] in the form of 'voice'.

Situating the study within a narrative methodology enabled me to tie 'story' to the concept of 'voice'. Voice contains both explanation and expression.

6.1.1.2 *Constitutive or constitute*

The narrative literature sets out a 'story' dichotomy in terms of 'constitutive' and 'constitute'. The happenings of our life are ordered by others external to us [constitutive] or we choose to make our life happen [constitute]. In relation to Figure

6.1.1, we may source external resources pertaining to pain care [constitutive] or we may rely on the resources contained within ourselves [constitute].

6.1.1.3 *The linkages to ‘head’*

I linked explanatory to ‘knowing’ [head] to reflect the participants’ thinking about pain. Participants sourced external resources in terms of attempts at finding understanding or being instructed on the care of unresponsive patients’ pain [constitutive]. Participants also shared internal thoughts and beliefs about pain [constitute].

Likewise in this thesis, I have explanatory parts, ‘knowing’ [head] that have come from external sources such as the literature [constitutive]. There are also explanatory parts of the thesis that show the thinking developed through the work of this study [constitute].

6.1.1.4 *The linkages to ‘heart’*

I linked expression to ‘being’ [heart] to reflect participants’ core inner processes in caring for pain in unresponsive patients. Participants practiced within professional expectations which defined the nursing role [constitutive]. Participants also shared internal motivations for, and responses to, their nursing actions [constitute].

Likewise in this thesis, I have expressive parts ‘being’ [heart] that present expectations of nurses’ internal positioning from external sources [anecdotes] [constitutive]. There are also expressive parts that convey our heartfelt responses to this study [constitute].

6.1.1.5 *The linkages of the six human needs*

The opposing tensions in the six human needs dyads are aligned meaningfully with the ‘constitutive’ versus ‘constitute’ dichotomy as well as the schematic ‘head’, ‘heart’ and ‘voice’.

6.1.1.6 *Certainty/uncertainty [head]*

We may be certain or uncertain in our ‘knowing’ [head]. ICU nurses are expected to be certain when they practice [constitutive] yet the reality of the inexactness of uncertainty permeates every moment of pain care in unresponsive patients [constitute].

6.1.1.7 *Growth/contribution [voice]*

We may grow from receiving [listening] or contribute through giving [speaking] various forms of communication [voice]. Situations that engender growth or resources for

development are located external to nurses [constitutive], whereas contribution involves nurses giving something of value to others from within themselves [constitute].

6.1.1.8 Significance/connection [heart]

We may be significant or connected in our 'being' [heart]. To be significant requires external others to appraise and deem nurses to be important [constitutive], but for nurses to achieve connection with others requires them to put individuality aside and participate in community [constitute].

The explanatory findings in section 5.4 presented opposing notions the nurses raised as difficult to live within or choose between. [For example, cure versus comfort.] Linking these opposing notions that the nurses have to contend with to the 'constitutive' versus 'constitute' dichotomy provides for a complex discussion of the reality of nursing practice within the rhetoric around nursing.

6.1.2 Example of cure/comfort

Taking the dichotomy of cure and comfort in ICU, the extreme positions are; patients are so comfortable they are dead or patients have to be in so much pain in order to recover to get out of ICU alive.

6.1.2.1 Linking to 'head' and 'constitutive'

So linking cure/comfort in the top right of the diagram to 'constitutive', I would be looking at what is expected of nurses in terms of 'head', that is, the knowledge nurses would be expected to have about cure/comfort. One such expectation would be that nurses believe patients are being treated by the advanced technology of ICU because patients want to live.

6.1.2.2 Linking to 'heart' and 'constitutive'

I also would look at the 'constitutive' point of view around 'heart', that is, how we are expected to 'be' as nurses in respect to cure/comfort. One such role expected of nurses would be to provide comfort.

6.1.2.3 Linking to 'head' and 'constitute'

Linking cure/comfort in the top/left of the diagram to 'constitute', I would be looking at nurses' internal thinking [head] about cure/comfort. One such belief was that nurses thought it was okay for patients to experience a reasonable level of pain in order to get their tube out.

6.1.2.4 Linking to ‘heart’ and ‘constitute’

I also would look at the ‘constitute’ point of view around ‘heart’, that is, what nurses have talked about ‘being’ in relation to cure/comfort. One such response was nurses’ frustration.

6.1.3 Global linkages

So I took the dichotomies of issues that the nurses raised in the interviews and then, as the cure/comfort example shows, applied it to all the concepts of my diagram. Because I needed to form thesis sections, I divided the issues into ‘head’ and ‘heart’ in accordance to the linkages that made sense to me.

Obviously life is fluid and stories are changeable and so setting up the schematic diagram of Figure 6.1.1 to depict intertwining concepts is at best helpful rather than representative. Our life-world is in the middle. All of the concepts in the diagram apply to nurses at different times and in various situations.

Relevant parts from the schematic diagram are shown in Chapter 7 to track through how the issues raised by participants relate to the concepts of the thesis.

The upcoming synthesis sections follow a division of issues that align with concepts in Figure 6.1.1. Pain care - *seeking certainty in ‘seeing’ and ‘doing’* in section 7.1 covers the assessment and management options nurses raised and the literature to which they relate – what nurses ‘see’ and ‘do’. Epistemology – *‘thinking’ through uncertainty* in section 7.2 discusses issues relating to ‘head’ – what nurses ‘think’ – and ties them with ‘voice’. Ontology – *‘feeling’ within uncertainty* in section 7.3 discusses issues relating to ‘heart’ – what nurses ‘feel’ – and ties them with ‘voice’. Storying – *‘telling’ of practice* in section 7.4 presents options of ‘voice’ to put in place ways of meeting nurses’ six human needs in terms of formally applying concepts from Figure 6.1.1. Throughout the synthesis sections I have shifted my reference to nurses as the collective ‘we’ for internal consistency with my co-participation and co-creation of story.

Chapter 7: Synthesis

7.1 Pain care - *seeking certainty in 'seeing' and 'doing'*

A continual cycle in nursing is assessment and management then assessment and management. We measure vital signs, ask patients to tell us what their problems are, observe by using our senses, then we use the information gained to create a picture on which to decide what the most appropriate nursing care is for these patients. The responses of patients to or the outcome of our nursing care is evaluated by going back to assessment and so the circle continues. As a result what we do in our nursing care depends significantly on what we see. This section covers a synthesis from nurses' words, the literature and my understanding of the process of assessing and the options for treating pain and providing comfort for patients whose experiences are contained within their body and are not available for our perusal.

I began the journey of the thesis investigating pain and now at the conclusion of that journey I have a story about nursing. I remember whilst analysing transcripts thinking that I had intended finding information from nurses about pain but what they had told me was about nursing. I understand from this that it is not easy to filter out and discuss one part of the complexity of nursing, instead, the nurses needed to tell me the whole story in order to explain about pain. Nevertheless, the story does focus on pain in unresponsive patients in ICU.

Typically ICU patients cannot clearly communicate their pain (Christoph 1991; Kelleher 2006), especially those unable to talk, write or indicate cannot even use the finger span scale (Merkel 2002) or blink in response to 'yes' or 'no' questions (Pasero and McCaffery 2002), therefore defining pain subjectively on what patients say was unworkable within my area of interest. I undertook this study to find practical wisdom from my colleagues. Section 7.1 discusses answers from the co-created collective story. The nurses I spoke with in this study told of their understanding and experience of the complexity of pain in relation to comfort and also articulated other dimensions of discomfort, such as nausea and fatigue that intertwined with pain. Isolating pain, as only one part of the patient experience that these nurses managed, was not possible. In this section I will cover the concepts of 'seeing the silhouette' and 'the contents of our satchels' from the dark room metaphor. So that the thought content can be easily

read without distraction from the oral form of expression, quotes from the transcripts have been 'cleaned' [notations reflecting speech removed].

7.1.1 About conceptualising pain

I conceptualised pain on one end of a continuum opposite to comfort in order to gain an understanding of what it *is* through comparing it to what it *is not*, although comfort too proved to be a complex concept. To begin with, the word 'comfort' is semantically difficult as it can be a verb, noun or adjective and can refer to a process or outcome (Kolcaba 1992; Kolcaba 1992). Also, comfort can be separated into physical and emotional dimensions (Goodnow 1935; Orlando 1961; Paterson and Zderad 1988). Kolcaba (1991) divides the concept further by talking of physical, psychospiritual, environmental and social comfort. I intended to look solely at the physical dimension of comfort, however, the complexity of unresponsive, critically ill patients lent itself to tie in with the complexity of comfort. Comfort, as a description of the experience of patients, an outcome of nursing care, has a structure that is complex and personal, with different degrees of intensity (Kolcaba 1992); "...comfort is multi-dimensional, meaning different things to different people." (Hamilton 1989, p32). Comfort, as a verb, is derived from a Latin root *confortare*, meaning to strengthen. This process of comfort occurs when nurses empower patients with respect to their bodies; enhancing strength and health (Morse and Carter 1995).

7.1.2 About our pain assessment options [seeing the silhouette]

The options nurses took to assess pain came from a combination of what pain cues we could physically see, what we could imagine from nociception, assumptions about pain and analgesia, relatives' views on pain and our response to patients. This sub-section 7.1.2 presents the specific facets of our collective picture of these patients that led us to believe they were either comfortable or in pain. For example, being dead was assumed to be the 'ultimate comfort' in contrast to several aspects of recovering which are assumed to be painful, and yet analgesia is often restricted in a recovering patient. We interpreted calmness and stillness in a patient as being comfortable and we used patient peacefulness as a measure of nursing skill. This led to the paradox of a still and silent patient experiencing pain where nurses assume comfort, in which case the magnitude of the omission is not immediately available; it can be overlooked and nobody knows the effect except perhaps the patient. Relatives may help us to look specifically at patient's comfort by asking questions or merely being present. Our personal response to the patient's relatives, whether we like them or not, or feel intimidated by them, may make it easier or harder for us to do comfort care for these

patients. As each nurse is assigned the care of varying patients over their days of work a time lapse in assessment occurs at each change of shift.

Herr, Coyne et al (2006) and Puntillo, Pasero et al (2009) cover similar sources of pain information to what we used when they recommend the use of McCaffery and Pasero’s (1999) hierarchy of pain assessment techniques as shown in Table 7.1.1. Their suggestion for the use of behavioural scales, minimising the emphasis on physiological indicators fails to adequately address the paradoxes inherent in, and the complexity underlying nurses’ use of, each category of information. They note the importance of continual reassessment and documentation.

Table 7.1.1 Hierarchy of Pain Assessment Techniques

1. Patients’ self report
2. Consider potential causes of pain to patient
3. Observe patient behaviours
4. Consider surrogate reports of pain by others for patient
5. Trial of analgesia

7.1.2.1 Assuming pain from physical signs [paradox of other causes of physical signs]

The physical cues of pain that we noted included: tachycardia, hypertension, muscle tension, sweating, grimacing, gritting teeth, red face and large pupils. However, we also noted that these physical changes may be attributed to other pathophysiology associated with being seriously ill. The complexity of speculating the correct cause becomes less anxiety producing over time.

Taylor Well, initially if they can’t communicate if they’re tubed or, as you say, if they were sedated or something like that, initially you can look at their vital signs and see if they’re in pain, like if their blood pressure’s going up or if their heart rate or if they’re tense or red face or obviously gritting their teeth, they’re in pain, if they can’t communicate. (9:1,17-24)

Beth I look for things like tachycardia but then that could be a sign of bleeding too, so you can’t just go on that. Sometimes when you’re moving them if they get stiff, all tensed up that’s a sign of pain, and when you’re moving them, just for coughing and suctioning, you can see them grimacing, facial movements, you know the sort of expressions. Sometimes when they’re in pain they get a bit clammy. (7:2,4-13) I suppose pupils size sometimes could be a bit of an indication too. Especially in somebody like this who is unconscious. If they’re large they could be in pain, but also frightened too so may need to be given a bit more sedation. (7:3,8-13)

Toni I think, you have to go on their clinical signs, like if they’re getting really tachycardiac when you turning them or they’re grimacing, or they just look very uncomfortable. Its hard, I don’t know how. I think sometimes you

can just tell if you patient's in pain or not. Just sort of like a gut feeling, or, if the people have had some major type of surgery, you obviously think, "Well they probably will be in pain." Some big procedure, if they haven't got adequate pain relief, it can sort of impede their recovery, (6:1,30-39)

Robyne If they're not grimacing, and maybe this is a wrong assumption, but maybe they're not perceiving pain. (3:6,16-18)

The work of LeReshe and Dworkin (1988) was able to produce as a visual image the facial expression of actual patient pain. Others have built on LeReshe and Dworkin's work using experimental pain, finding that there is a consistency of facial muscle contraction in response to electric shock, cold and pressure. The four principle facial actions of pain are: brow lowering, orbit tightening, eyelids closing and mouth stretch. (Prkachin 1997). Participants used the cue of grimacing to identify pain experience. I wondered to what extent the facial expression might be impeded through level of illness or sedating medication.

7.1.2.2 Assuming pain from restlessness [paradox of calm patients in pain]

We determined what pain unresponsive patients were experiencing by what patients looked like. Sometimes these patients gave no indication of their pain or comfort. They lay still or were pharmacologically paralysed and had normal vital signs. At other times, behavioural and physiological cues exhibited by these patients were subtle and could have originated from causes other than pain or discomfort.

Rhea agitation could not necessarily just not be cerebral irritation it could be severe pain (8:3,18-19) because you automatically know that if they're starting to get restless and irritated and you know that its probably pain or discomfort from the tube, or discomfort in the bed. (8:10,7-11)

Puntillo et al (2004) validated grimacing, rigidity, wincing, closing of eyes, moaning and clenched fists as behaviours that could indicate pain in unresponsive patients. The Behavioral Pain Scale [BPS] assesses facial expression, movements of upper limbs and compliance with ventilation (Payen, Bru et al. 2001). However, Ahlers et al (2008) found that compared to numerical self-rating, the BPS can score patients as having less pain than they are actually experiencing. Chanques et al (2006) found using the BPS in conjunction with the Numerical Rating Scale for pain and the Richmond Agitation Sedation Scale in a systematic way reduced the incidence of pain and agitation while patients were ventilated.

The Nonverbal Adult Pain Assessment Scale [NVPS] assesses face, activity, guarding, vital signs and physical signs (Odhner, Wegman et al. 2003). The NVPS correlated well

with the FLACC [Face, Legs, Activity, Cry, Consolability] pain assessment tool for children (Merkel, Shayevitz et al. 1997). Wegman (2005) adjusted the NVPS by replacing the vital signs with ventilation compliance. Kabes et al (2009) validated the change as more indicative of pain.

The Critical-Care Pain Observation Tool [CPOT] assesses facial expression, movements, muscle tension and vocal sound or ventilator compliance (Gelinas, Fillion et al. 2006). Testing of this tool has confirmed its worth (Gelinas and Johnston 2007; Gelinas, Harel et al. 2009). However, none of these tools are appropriate when patients are paralysed (Cade 2008; Helms and Barone 2008). Li et al (2008) add that the available objective pain measures still require further testing for validity and reliability.

We assume a calm patient is a comfortable patient but sedation helps patients to look calm. The by-product of assuming comfort in settled patients is the judgment of other nurses that if your patient looks comfortable you are a good nurse.

Patient sleeping peacefully = ‘good nurse’ 😊

Patient restless = not a ‘good nurse’ ☹️

The awful paradox of assuming calm patients have no pain is that calm patients may be in pain but just not able to let nurses know.

Asha ‘cause they still feel pain. That’s the other thing, they just can’t communicate it. We don’t know how unconscious they are. I’ve had narcotics before, obviously not in an ICU, and have felt uncomfortable, but I’ve been just too drowsy to communicate it, and in the morning when the nursing staff come ‘round they say, “Oh she slept all night,” and even though you just sort of open your eyes and try to say, “Help, my teeth hurt”, but you can’t because you’re too doped out, and that must be more so with our patients, (2:2,23-34)

When ICU patients look calm, nurses can let their focus on pain care slip to the background because pain cues are not ‘in your face’. Patrick explained how thinking about pain can become a lower priority. [The doctors were limiting analgesia and sedation for patients in renal failure.]

When their creatinine and urea, their renal function goes off, just switch those things [analgesia and sedation] off. What do you think about that? Its a strange thing, because you’re thinking, “Oh god, you know, I should be giving some sort of pain relief here.”, and you’ve got none of your normal indicators that somebody’s in pain that it sort of seems that it slips into the background a little bit, sometimes you even forget the fact that you know that he’s not on morphine or midazolam infusion and I guess sometimes when you’re at the beginning of the shift, and you’re looking through all the infusions, you go “Oh!” you know, “Should I give them a bit of a bolus?”

But, to me, its a little bit easier because you know that physiologically it would be detrimental, would further put them backwards if you did have them on a morph and midaz infusion and give them pain control. (5:6,29-7,15)

Pharmacologically paralysed patients certainly cannot indicate consciousness and so the possibility of being acutely aware and yet seemingly peaceful would be most likely to manifest in these patients. Patients remembering pharmacological paralysis had thoughts of being buried alive or, if not conjunctively receiving psychotropic drugs, panic through the time they were paralysed and then experienced post traumatic stress syndrome afterwards (Perry 1985). Other themes to emerge from memories of paralysis include: travelling 'back and forth' between alive and dead, loss of control and feeling that they could do nothing, fighting, being scared and feeling dead. Curiously, among all these negative thoughts patients felt 'cared for' by nurses (Ballard, Robley et al. 2006).

Rhea told of a patient who remembered being awake in theatre. I actually looked after a man in my first ICU job, who had gone to theatre for the third time and was paralysed and not sedated or analgesed, because it was a rush back to theatre, they hadn't the time, so... he woke up and he was writing on the piece of paper, "I was awake, I was awake", and I nearly died, but he was he was actually a friend of my family and knew my father, and I met him since then, and he didn't want to do anything about it because basically they'd saved his life and he walked out of hospital, but he said it was the most frightening experience in his life and he said he was mentally shouting you know "Its sore, its sore, stop, stop." and couldn't do anything, so I've always remembered that and there's no way you would never not sedate somebody. (8:8,19-35)

7.1.2.3 Assuming pain from nociception [paradox of inflicting pain]

Loeser's (1982) pain model, where each concentric circle adds another dimension to patients' overall pain experience, contributes to the conceptual options available for nurses when perceiving pain in unresponsive patients. From Loeser's model [see section 2.1.2.7] nurses can understand that indications of pain manifested by patients are superficial to the whole experience. A recent easily readable book written for pain sufferers by Butler and Moseley (2003) shows an updated biopsychosocial pain model they attribute to Loeser and Waddell in the shape of a cross-section of an onion. The extra outer ring is 'social environment'. We may sometimes be aware of the social environment contributing to unresponsive patients' pain when dealing with the relatives. However, the message remains that patients experience much more complexity in their pain than they indicate to us.

Leticia I think pain is something that they all experience, and discomfort, especially if they're an unconscious intubated patient (1:1,36-2/1)

We considered how the illness or injury of the patient would cause tissue injury and thus pain in a direct way like Descartes’ specificity theory.

Toni I think he would have been in a lot of pain, ‘cause he had lots of fractures, (6:p3,18,19)

S [a doctor] came and said “he’s only had a nephrectomy, he hasn’t had a thoracotomy, he won’t need as much pain relief as someone who’s had their chest opened.”(1:13,26-28)

Intercostal catheters are very painful *Yeah, I guess the only thing I’ve been told is that anything going through your rib cage is really painful, like intercostals are really painful* (1:14,6-8)

In the same way, we considered the tissue trauma we inflicted on patients when doing procedures. Non-intentional pain that happens as a result of the care that nurses give is something to be avoided but we had heard the horror stories from patients relaying memories and nurses seeing things happen or experiencing themselves the procedures they apply to patients. Hall-Lord, Larsson and Bostrom (1994) found patients experienced distress in response to nursing procedures. There have been specific procedures that patients have remembered to be distressing while in ICU.

Suctioning has been described as painful (Arroyo-Novoa, Figueroa-Ramos et al. 2008), especially when the endotracheal tube is moved during the procedure, (Henschel 1977; Earl 1979; Turner, Briggs et al. 1990) and distressing when patients feel they cannot breathe (Johnson and Sexton 1990). Suctioning also causes pain at the incisional sites of surgical patients (Puntillo 1990). Drain removal and position change also caused increase pain (Siffleet, Young et al. 2007).

Leticia talks about suctioning, And of all the things that you do, like suctioning, sort of the easiest and you just go and do it, you know that causes them distress and yet that’s always when they want to get the tube out and move around. Like you can do most other things to someone and they tolerate it but suctioning is something that’s just horrible, and you just go, “Oh, a bit of a cough coming up now.”, and ram this tube down their other tube (1:10,11-19)

Two of us had heard previous patients talk about the effect of suctioning. *I was as at a conference, one of the guys, it was at another ICU, came back and he was talking about suctioning being really dreadful, I don’t know, whether he said it was painful, but he said that he felt like he was choking, and he also said that physios were a lot more gentler than nurses. I went back from that conference thinking, “Oh, I should be very gently now with the suction,”* (6:15,30-37) *and he said he hated it when they said “just one more time.” How many time do I say “Just one more time.”? All the time* (1:10,21-23) Rhea related, we were at a respiratory conference actually a couple of months back with the unit and the guy there said he spoke to a patient who said it was like the living air had been sucked out of him. You know when you cough and you have something caught in your throat and you cough and cough and you just have to try and catch your breath, but you knew it was going to happen. He was describing it as a fact that you’d sucked every last drop out of him and he just felt that he was never going to get a breath because the suction catheter had taken up everything. So if you think you’re doing that every hour or more frequently on the patient, I mean, they must be just exhausted, the mental

anguish you go through at the same time and you can't catch your breath, it would be horrible. 'Cause I mean your basic instincts are that you breathe and you just can't do it, it must be horrible. I have remembered that. How do you suction more gently, I mean, there is a point where you just don't ram the catheter down and back up again but... the quicker you can actually do it, its probably the more sensitive thing to do. (8:28,18-29,4)

In an early investigation of the effects of suctioning, Boba, Cincotti et al (1959) found hypoxia to be one of the hazards. More recently, the deleterious effects have been found to also include: trauma, atelectasis, cardiovascular changes, intracranial pressure alterations, pneumothorax and infections. Therefore, in a review of the current available literature, Pedersen, Rosendahl-Nielson et al (2009) recommend: to only suction when necessary and only as far as the carina, always using an aseptic technique, preoxygenating, using low pressure and a suction catheter half the size of the diameter of the endotracheal tube.

The necessary attachments to the ICU patient causes restricted movement and often pain. Pain is felt greater at night and is exacerbated by sleep deprivation (Stanton 1991). Patients remembered the relief after their position was changed, although the actual turning was frightening and uncomfortable (Heath 1989).

I related what one of our previous patients had told us, *she came back [talked to us in an afternoon tutorial] she was a multitrauma, had fractured ribs and a flail and... fractured limbs and she couldn't remember much either, but she could remember being turned, which she said was really painful being turned. But she didn't know anything and then all of a sudden she was being turned and she said it was like falling down into a big deep pit 'cause it was just so painful.* (6:15,18-26)

Sometimes patients are positioned uncomfortably, with tubes and connections pulling (Johnson and Sexton 1990).

Asha talked about nurses who do not focus on patients' comfort, you see them turning a patient, or when they're trying to sit them out or something like that, and you just think, "Oh, that catheter's pulling", or "Watch her head" or, "You've got the tube across here, no wonder they're gagging on the ventilators" (2:1,31-35)

Arterial blood gas sampling was remembered as distressing (Clarke 1985; Johnson and Sexton 1990; Turner, Briggs et al. 1990).

Toni personally experienced an arterial stab. One of my friends did a blood gas on me last year, 'cause I wanted to see what it felt like, 'cause I always used to say, "I'm just going to do a little prick, it'll hurt a little bit." 'Cause we used to do them all the time... I just wanted to check my haemoglobin just on a gas, so I thought, "Oh well," so I said, "Just do a blood gas." It was just excruciating, it was terrible, it really, really hurt. I had pain radiating all the way up my arm. 'Cause, you know, how you always say, "Oh, it'll hurt a little bit." It was absolutely dreadful, it was worse than having a blood test or a cannula put in, really hurt and then it

throbbled afterwards. And it wasn't as if she did a bodgie job, 'cause she got it straight away, and after that I've always been, "This will hurt"... I think you're better to be honest (6:24,14-34)

Assessing neurological function by applying painful stimuli to gain a motor response is a paradox in our nursing mandate when we have to inflict pain rather than relieve pain. Tosch's research (1988) found that one patient remembered nipple pinching, often used as a method of applying noxious stimuli to assess neurological function. Nipple pinching is quite traumatic, causing possible contusion (Jennett and Teasdale 1981). Jones (1979) and Teasdale and Jennett (1974) say the application of pressure to the nail bed is more appropriate. In our unit there was a differentiation between central and peripheral noxious stimuli, with the response obtained depending on where the stimulus was applied. On the doctors round, central stimulation is applied by sternal rubbing, nipple twisting or pinpricking the upper lip. Whereas nurses tend to use peripheral stimuli, such as pressure to nail beds. Whatever method is used, inflicting pain in this circumstance is viewed as necessary for the clinical assessment of neurological function; meaning that the need to know physical functioning is held more important than patients' need for physical comfort.

Frequently inflicting pain for neurological assessment over an extended length of time calls into question its benefit. Patrick relayed his concern over application of painful stimuli Neuro assessment of people who are really deeply unconscious, very deeply sedated because of their injury and also you're doing neuro-obs because of their injury and I sometimes wonder what it must feel to have that deep pain instilled. *Every hour.* Is it necessary to do that, would it be enough to have a look at the pupils every hour? Because do you really need to know whether somebody's moving their right hand every hour? I don't know whether, you would stop moving your hand first before you blow a pupil. *Are you talking about the type of patient that's like ICP[intracranial pressure] monitored and on Lignocaine and sedation?* Yeah, but I think there's also another group where they're not doing much and they're been with us for a while and the old needle comes out and you know, *Ahhh.* Aw, and I wonder whether that's particularly necessary. I think its necessary to do it a few times a day. *Sometimes they've changed it to once a shift or on the doctor's rounds but that's generally later isn't it?* Yeah a lot later in a sort of very safe period, but I guess the argument again is, what's the physiological precedent or I don't know? *So instead of being "Are you dead or are you comfortable?", its "Are you dead or will we inflict pain on you to make sure you're not dead?"* That's right. I think I'll just have a game of chess to see if my brain's still functioning. (5:24,27-25,27)

Participants also spoke about other assumptions of pain effects such as:

1. Dressings are more painful than turning
2. Open abdominal wounds are painful
3. Multiple fractures are more painful than head injury
4. Burns are extremely painful

7.1.2.4 Nurses imagining themselves in patients' situations [paradox of nurses instead focussing on patient recovery]

Nurses imagined what it would be like to be the patient to help deduce what pain patients might be experiencing. Yet the busyness of ICU and the priority of keeping patients alive diverted nurses' attention from such imaginings.

Beth well, most probably I then think, "Would I be in pain in this situation?" (7:1,37-2,1)

Toni And even when you're suctioning people, it must be really awful and uncomfortable and if you'd had huge abdominal surgery, the last thing you'd want is somebody to be tipping you over every couple of hours and that's when I think we obviously see things.. (6:4,6-10)

Asha but if you lay in the same position for two hours and you were fully conscious, but you couldn't move, it'd be really uncomfortable (2:2,15-17)

Pain and discomfort has also been associated with the tube; sore/dry mouth, nose and throat and gagging (Gries and Fernsler 1988; Heath 1989; Johnson and Sexton 1990).

Patrick imagined the feeling of having an endotracheal tube inserted. Well, your airway'd be so inflamed, and like coughing while you've got a brand new cold, I guess, and you can't breath in air. (5:5,27-30)

7.1.2.5 Assuming pain from the input from relatives [paradox of needy relatives distracting attention from patients]

Patients' relatives influenced our consideration of patients' pain because the presence of family focussed us on comfort.

When speaking with Patrick I thought *when the patient's relatives are going to come in, you also look at the patient in a different light, I do anyway, look at them through what you think the relatives are going to see.* (5:20,26-30)

Contact with relatives caused Patrick to reconsider his patient's comfort and pain, he said, when relatives ring to see how the patient's doing, especially with the ones that are really unconscious I think we'll always make a point of saying, "Well, they're comfortable and they're pain free," and I've guessed that they're pain free. If nothing else, it still makes you think, you know, "Is he really, he or she really pain free or not?", At least it comes back into your brain and makes you look at it again, and see whether they are or not. (5:20,13-25)

We made the patients comfortable for the relatives to see. Patrick felt I guess its something I've thought of and feel that maybe we're sort of delaying the time between the patient arriving and actually letting the relatives in for the relative's sake, to have the patient nice and comfortable and pain free and clean sheet and I think that's another one of those things where we just take a guess, because I think sometimes that is good for them and other times people just prefer to come in no matter what. *People are sitting out in the waiting room biting their nails.* I know, its like errr!! *Let me in the door.* And nothing brings it home better than having to sit in a waiting room yourself in another hospital in intensive care, (5:20,31-21,17)

Relatives can fill out the picture of patients because the patients' friends and family are often the best source of information.

Bryce we think we're making them comfortable rolling them from side to side, but does that person really sleep on side to side, they might sleep on their stomach and just solely their back, no wonder they get tense when we put them on the left side and their right side. So the relatives come in and say, "Oh no he hates it on his side, he just can't stand that. He always sleeps on his back." So that comes from them, especially spouses would be the closest, if they're sleeping with them every night in a double bed and if they've been sleeping there, especially an elderly person, say for the last thirty years, then you've got someone who knows this person back to front. (4:3,21-33)

Demanding, unattractive or aggressive relatives may take our attention away from the patient. We found that family members often wanted information about patient's pain or comfort when there was minimal information available. Sometimes relatives asked us directly about comfort.

Taylor told of a patient, a person who couldn't communicate.. (9:4,17) it was a head injury, and... all his vitals were OK, he was just laying there. He looked comfortable but the relatives kept asking me, "Are you sure they're not in pain?" And they weren't on any infusions or anything and I wasn't certain that they weren't in pain (9:4,24-29)

Relatives of critical care patients are in crisis and need support (Chen 1990; Woolley 1990; Leske 1991). From the relatives' point of view, aspects of this support include: information, assurance of good care for the patient and comfort for themselves (Woolley 1990; Leske 1991).

7.1.3 About the goal of intensive patient care

Robyne was unsure where to aim her care because she was unsure where the patient was at you don't want to over-sedate them, you don't want them to be there in pain, so, its a bit hard to know when exactly, what's too much, what's too less when you not getting any feedback. (3:1,31-35)

Especially in ICU, patient comfort is sometimes subordinate to the medical goal of cure (McIlveen and Morse 1995). The harmful effects of acute pain in critically ill patients include increased myocardial work, slower wound healing, higher tendency to thrombosis and embolism, and poor immune function leading to sepsis (Cheever 1999). Being in pain is not desirable yet being pain-free and recovering is not always possible. With so many options for treating pain available to us, as well as ways of providing comfort to patients, we see pain as an unnecessary experience - or at least one we can minimise while patients are recovering and completely eliminate if patients are dying.

For us, patients were sometimes uncomfortable when they were assessed neurologically, weaned from ventilation or had organ failure, and analgesia or sedation were restricted. Often it was not possible to have a pain-free, recovering patient.

Patrick thought you're biggest concern in intensive care when they're critically ill is their medical side of things, and I think to me that needs to take precedent because, they go off so quickly (5:10,5-10) "Do you want to be pain-free, or do you want to be dead?" I mean, "Do you want to have pain or do you want to be dead?" ... I think that its easier for some to justify that someone is in a little bit of pain, as long as that's not for a prolonged period of time, like normally turning or and as soon as we've turned him they can settle down. You justify the fact that they're in a bit of pain. (5:10,16-26)

I thought when... *the plan was to wake the patient - then I have to walk the fine line of less comfort and more consciousness (Nbview.doc:1,33-34) its a weigh up thing. If you make them pain-free then they're not going to be as well physically. (5:10,28-30)*

Restricting analgesia and sedation during weaning from ventilation or when body systems fail are times when we are unsure what level of pain is acceptable for patients to experience.

Asha we used to get a lot of traumatic head injuries, you know, kids in car accidents and things like that, all sorts of things, and they'd want to wake them up after twelve hours and they'd be cerebrally irritated, thrashing around the bed, and oftentimes I remember saying, "This kid's in pain, you know, we've got to give him something." "No, no, no, we can't give him anything." 'cause they're neuro And I felt that they were in pain because even though they were cerebrally irritated, was because they had broken legs or something as well. But that was it, because they were a head injury, even though they've just had a stinking great rod put down their femur, and their foot's been crushed and they've got facial fractures, because we used to get all horrible things like that, they weren't to be given any morphine, because they wanted to see what they did because they had a headache and, as I said, they'd be thrashing around the bed, but oh boy, they must've been in pain, as well. You just must if you've got a fractured leg, and as I say, if these people were in the orthopaedic ward and quite compos mentis they'd be given a regular four-hourly narcotic.(2:14,19-15,5)

Asha we've had patients and they [doctors] want to wake them up and they've just had major abdominal surgery and they say, "Stop everything.", and you go, "Hang on, you know, if they were on the ward they'd be getting four-hourly morphine or pethidine." As you say, its just that they can't tell you, but no, they want them to wake up to get the tube out. Well surely there's a fine line where you can still.. obviously, there must be because we give people morphine who are conscious and breathing but yeah, we forget.(2:12,34-13,6)

With all the effort we put into saving lives of patients in ICU, death feels like a failure and yet sometimes we 'pull out', allowing patients to die. In either case we do not feel happy about death, rather frustrated by being defeated or simply relieved that the struggle is over for the patient's sake. Girard and Raffin (1985) describe two major goals of critical care areas; to restore health and relieve suffering, or to enable peaceful and dignified death. "Critical care units are set up to save lives. By design, dying

patients are not supposed to be in these units...Yet units have high death rates, and patients stay in the units after Do Not Resuscitate orders have been written. The realization of futility comes unevenly to nurses, physicians, patients, and families.” (Benner, Tanner et al. 1996, p224)

Providing comfort to dying patients is a priority (Campbell and Field 1991; Benner, Tanner et al. 1996; Maxwell and Pope 2006). Usually dying patients were administered morphine and midazolam but nurses were frustrated when the order was too conservative [patients believed to be experiencing pain] or too liberal [nurses might be 'killing' patients (Canzian and Dabbs 2008). Believing that the process of dying was inherently painful and not having to balance our pain treatment options to maintain recovery, we used all our resources to make sure dying patients were pain-free.

Beth thought in that situation I most probably would give quite a bit. Just in case. (7:4,16-17) Yeah, most are a real comfort issue (7:4,25)

Petra had a rule of thumb I think you've just got to sort of pick a reasonable number and double it and add one, because basically, you're not going to do them any harm if you give them too much, its still going to be the same end, but you're going to do them a lot of harm if you don't; if you under control their pain. So I always turn in that situation, and tend to go for the more is better. (10:6,12-20)

Taylor revealed the dilemma we face believing dying hurts when she advocated for analgesia for a homeless woman who was dying. There was another lady, I think it always happens to those.. she was a bag women, she was in ITU [intensive therapy unit], obviously a street women but hadn't kept herself very well and it was like the doctors didn't care as much about her as the other patients, they knew she was dying and she was NFR [not for resuscitation] but they didn't write up pain relief for her in her last and I remember one of us had to go and ask the doctor's to write her up something, 'cause she was NFR but she was lying there, just deteriorating, just rotting away and had no pain relief and every other patient had it. I just found that a bit, you know. I think that those type of physical, social stuff come in to how the doctors treat people. Cause we had to go and ask for her to have pain relief and a bit of dignity while she died. That was in our unit too. (9:14,31-15,14) I mean the doctors shouldn't have, they should treat everyone as equal patients, I know it doesn't happen you can see it (9:15,20-23) they were just the ones that swap around [resident medical officers] but they should have written up pain relief for her, just to die comfortably, she was dying anyway. (9:15,28-31)

Feeling relief from the struggle to maintain life does not leave us without uncertainty while caring for a dying patient, we may have qualms about 'killing' these patients by our administration of narcotic or we may just want their suffering over. There is a very strong ethic in nursing not to cause harm (Catalano 2008).

Taylor she had a butterfly [needle] in her arm, so I was just giving her, she had PRN boluses, any PRN, there wasn't any time limit, and, 'cause I hadn't worked with her, I didn't know how PRN I could, like how much, how frequent I could give it, and I remember just going up to the doctor and, I mean, they knew she was going to

die soon and could see that she was in pain and I just didn't know, like if that little bit I gave her would pull her, or push her over the edge or I found it really hard and then the family being there and, you know, "What are you doing now?" and, practically I was giving her her last bolus. I wasn't killing her but I was making her comfortable. (9:13,13-27)

Robyne Essentially, they said, this guy was requiring so much adrenalin they'd pulled out and he didn't have any family, but that's a whole another issue. You can't.. O.K. you don't have any family, forget it, so they said, "Well we're ceasing treatment." So I turned the ventilator down to 30%, his saturations were about 40, and I gave him some morphine and he was dead in about ten minutes. And I had no qualms about doing that at all. I know that dose probably killed him, but he would have lingered longer if I hadn't have done that. But yeah, I mean, it puts you in a very moral position, doesn't it? *(yes and its an ethical sort of thing, but if you just purely look at it from a comfort point of view..)* I felt so, I mean, in that instance I wasn't going on his grimacing, I was thinking how awful it would be, how awful it would feel for you to be conscious and knowing that you were about to die, and I didn't want him to experience any pain whatsoever in that time, and that's why I did that. And because it was so hard to tell whether was experiencing 'cause he wasn't doing anything. You know, it was like, "You gonna die, I'm not gonna let this pain, you know, linger, make it longer." (37,5-28)

7.1.4 About our pain management options [the contents of our satchels]

This sub-section 7.1.4 is about the options we used to promote comfort and alleviate pain with some input from the literature. Participants spoke about analgesia and sedation and their gaps in pharmacological knowledge, touch [position, turning, mouth-care, hygiene, sleep, massage and aromatherapy], talk [comfort talk, preparatory talk, imagery/music] and involving relatives in care.

The options that we chose to relieve pain and provide comfort for the unresponsive patients were dependant on our learning, both through formal education and from experience. Bergbom-Engberg and Haljamae (1993) found that the use of these comfort options also depended on nurses' work load, their feelings for the patient and their own personal problems and worries. Further investigation of what this study revealed in terms of our forms of 'knowing' and 'being' in the complex context of caring for unresponsive patients' pain will be explored in the following sections. The discussion here is confined to the pain treatment options that we used and also others we thought might be possible in another place or time. Morse (1992) categorises the major activities of comfort as touching, talking and listening. With these patients, we looked instead of listened as they were unable to talk to us, however, we did touch and talk to them. As nurses we had autonomy over talking and touching, yet what we talked about most in this study were the medically controlled analgesia and sedation.

7.1 Pain care – seeking certainty in ‘seeing’ and ‘doing’

Ferrell and Leek (1991) suggest that the goal of pain management is not enough, nurses should aim to provide optimal comfort, including measures to relieve fatigue, anxiety, sleep disturbance, and analgesia induced nausea and constipation. Nurses should provide the same kind of pain management that they would for their own family member. Walters (1992) defines comforting as relieving pain and anxiety and suggests comforting activities include touch, position, massage, communication and medications. Coyer et al (2007) adds to this list: the hygiene measures of eye care, mouth care and washing; as well as the removal of stressors such as noise and light.

The Table 7.1.2 provides a summary of the pain management options included in the information from colleagues collected for this study. Each option will be discussed further in detail.

Table 7.1.2 Pain management options

1. Pharmacology	(a) analgesia	Action of narcotic and sedative confused
	(b) sedation	Relation to memory
2. Touch	(a) position	We can see – others can see and measure our nursing by whether the patient looks comfortably positioned– but may not in fact be comfortable
	(b) turning	We know and others can see if position has been changed frequently. Becomes routine – patient’s feelings not in our face so don’t think about them – just heave ho!
	(c) Hygiene (washing, grooming, mouthcare, eyecare)	Putting yourself in their place
	(d) massage	Question benefit further than feels nice vs seeing benefit of reflexology
3. Talk	(a) comfort	Minimising the severity of things – the idea of just to hear another human voice – background of torture
	(b) preparatory	There is a human inside this body – related to if its not in your face you can ignore it
4. Sleep		Grouping activities – focus on patient rather than what we have to get done – versus ‘looking busy’ culture. Putting aside unit norms for the sake of sleep – balancing need for pressure relief and sleep
5. Alternative therapies	(a) aromatherapy	Calm senses
	(b) music/imagery	Distraction

7.1.4.1 Pharmacology

Morphine was the main opioid and midazolam the anxiolytic of choice in our ICU. As nurses, we titrate the dose of both of these (usually in infusion) to the desired effect (pain relief or sedation). Helms et al (2008) suggest treating with analgesia first and to only add sedatives later as needed in order to reduce the amount of time patients need to be ventilated. Inappropriate use of analgesics or anxiolytics can worsen patients' distress. When anxiolytics are wrongly used to treat pain, patients experienced central nervous system depression but the hypermetabolic responses to pain continue to cause organ dysfunction. On the other hand, if narcotic analgesia is given to anxious patients who are not in pain, the side effects are intensified (Crippen and Ermakov 1992). Doctors and nurses in one study were found to hold misconceptions believing that paralysing drugs and benzodiazepine had analgesic properties (Loper, Butler et al. 1989).

We knew that paralysing drugs did not provide analgesia or sedation.

Asha remembered one night having a screaming argument with the registrar in another ICU I worked in, because he just wanted to give a tiny bit of morphine to a paralysed patient and saying, "You have to give them something sedative as well, you know, all the narcotic will do is just make them drowsy. You can't paralyse someone.." and we paralysed this patient just on a bit of morphine and we just had this screaming tachycardia, went really hypertensive and I just said, "We've got to give them something." (2:8,28-37)

Toni remembered stories of people intra-op who the anaesthetics haven't worked and they've been fully alert during the procedure but they've been unable to move or talk or do anything, and that would just be terrible. I couldn't think of anything worse. (6:21,17-23)

Sometimes we confused sedation and analgesia.

Leticia had a patient who had been on a sedation infusion of about two mls an hour, very small lady, and she had been unrousable on that, or very lightly rousable, she'd open her eyes, just, and that was it, and seemed very comfortable, and they [the doctors] stopped her infusion to wean her ventilation and she was continually grimacing and when I discussed that with the doctors they said, "Well we don't want to put her back on the morphine infusion..." (1:5,20-28)

Having a general notion that midazolam made patients forget gave us an opening of hope that if we were unaware of or unable to relieve their pain then they might not have to live with the memory of a traumatic experience for the rest of their lives. However, we also considered the immediate experience as important, not just its cognitive memory. Participants did not speak about possible cellular memory of pain.

Although there has been put forward the notion of ‘somatosensory memories’ that might account for phantom limb pain which is the experience of pain without the nociception. (Katz and Melzack 1990) memory for acute pain decays – becomes less over a passing of time from the event of pain (Kent 1985; Erskine, Morley et al. 1990). Memory of pain depends on the pain being experienced while recalling previous pain. If current pain intensity is high, the previous pain episode being recalled will be attributed with higher intensity. If the current pain intensity is low, the previous pain episode will be attributed as less severe (Eich, Reeves et al. 1985; Savoley, Smith et al. 1993; Smith and Safer 1993). Most patients who have a cognitive memory of pain do not actually experience pain again whilst remembering (Morley 1993; Wright and Morley 1995). However, in Storli et al’s (2008) phenomenological study, memories containing strong emotions were surprisingly well kept ten years after ICU admission.

Even though one Australian study found there was no correlation between the use of midazolam and ability to recall memories (Daffurn, Bishop et al. 1994), we connected midazolam with amnesia, but we were not clear of the pharmacology of this.

I thought if they’ve had midazolam, they’re not going to remember that short term bit around where they’ve had the midazolam. (5:22,3-5)

Whereas Petra thought the patients that do come back and see you before they go, especially a lot of the head injuries and that sort of thing remember absolutely nothing of the whole situation. I mean that’s probably a combination of the midazolam as well as just the whole experience. ‘Cause, the way I understand it, midazolam doesn’t just knock off your memory like for five minutes while its working but it has a sort of effect where it stops your short term memory of things that have happened in the last hour or so as well (10:8,7-17)

We tended to assume that patients who had received midazolam would not remember.

Toni said “I often wonder what people do remember when they’re out of it, like whether they actually do remember you going up and saying, “I’m going to turn you now Mr ,” or whether that you just midazolam them out, or, you just don’t know what they remember. (6:15,10-14) **and she thought** it would also be very individual as well. Depending on what they’ve had, and those sorts of things, to what they remember and you really wonder if it would be not precise, if they have had lots of midazolam whether they’re just kind of guessing at what they felt, like, whether they’re just sort of thinking, “Well, yeah maybe I was in pain, or maybe I wasn’t.” (6:16,24-31)

I agreed that patients’ memories helped us in our care, but I also thought there was more to the picture. *There’s been research on people remembering and pain I think was the second highest memory... but then I have problems with research on patients’ memories because a lot of people don’t remember because they’re not alive or they’re in a different sort of state with their head after being in ICU and what is the point whether somebody remembers it or whether they actually experience it at the time? That’s my point of view. So they could’ve been in horrific pain and not remember it because we’ve given them some midazolam but at the time it would have been horrible. (1:17,8-20)*

We thought it was good for these patients to forget their ICU experience.

Leticia considered it better for them to be over-sedated and analgesed I think... I mean I guess if someone comes back and says they can't remember it that's a good thing, rather than, "I remember all this pain."

(1:16,37-17,4)

However, I wondered about the effect of their experiences at the time: *if you don't remember a week later what you've gone through, does that mean that you didn't go through it? At the time it could have been really horrible and then because you've been given midazolam you don't remember, which is good for them, I think, its good for them not to remember but I think that they shouldn't have had to have experienced it in the first place, unless it was necessary, you know what I mean* (5:22,8-17) Patrick asked Which means that if you can't remember, do you conceptualise pain? (5:22,6-7)

After receiving a 5mg bolus of intravenous midazolam, amnesia begins after 2 to 5 minutes and lasts for 20 to 40 minutes (Irwin and Rippe 2008). Roberts et al, (2007) found that patient remembering of their ICU experiences continues to be inconsistent.

We thought that different types of opioids were better at treating different types of pain, however we were used to using only morphine.

Bryce volunteered, I guess alternative uses of things as well... do we specifically need to use morphine for every case, I mean, excluding those that are allergic to morphine, perhaps... pethidine may have been linked to a better management of, I don't know this but say abdominal surgery say the better manager of abdominal surgery whereas morphine is better for orthopaedic or visa versa. So OK, we might use pethidine in orthopaedic patients because the majority of studies have proved that, like Panadeine Forte is better for skeletal like bone pain

(4:23,14-26)

We had a vague idea about pharmacokinetics in a failing body.

Rhea didn't know where morphine and the metabolites go with liver failure, are they just going to the body to accumulate? (8:13,28-30)

Petra explained B brings this up in his lectures, actually, I can't remember it exactly, but basically, patients with like an overwhelming type of sepsis, I think it was, can get that quite agitated look about them but its not that they're particularly in pain... Its more a response to their actual septic state and because they've got liver problems, and they've got renal problems, instead of being able to excrete it [morphine] they're accumulating it and getting sort of more toxic by it and the more you give them the worse they actually get. So I mean, I don't really dispute that. (10:6,29-7,7)

Knowing that use of the narcotic agents that we use to treat pain has the possibility of creating chemical dependency in patients means that we are unsure of the longer effect of our treatment now.

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Bryce thought there's always that notion sitting in the back of our minds that we're going to give too much, and I guess we sort of lag back and then and we don't give enough then. (4:6,27-30)

We were unsure of the long term effects of these drugs. Patrick thought are we getting people a little bit addicted as well whilst they're in hospital? (5:17,1-3)

Rhea related an experience of limiting these drugs only for the reason of long term use. They [the doctors] tried to wake [the patient], withdraw morphine and midaz and stuff like that because of long term use *to wake him up* no, because of long term use and withdrawals. You know when they've [the patient] been on it maybe two or three months and they get the tremor and stuff. And they [the doctors] say that, they put that down to withdrawal, ...his tremor, although he had it pre op, but we didn't see, his friends and family said he did have a bit of tremor, but his was really noticeable and they were putting it down to withdrawal. But it would have to be a combination of morphine and midaz. (8:11,8-14,27-31) It's not that they [the doctors] were not trying to give it, like they sort of come to the conclusion that its time to stop. Its not, "Don't ever give it because of.." you know, its just they get to this point, its time we should consider stopping. (*Because they have the tremor and then they stop. Do they have the tremor after they stop?*) No, they've tried to wean or tried to wake them slowly and I've noticed that they put this bit of agitation down to, ...But they get to that sort of, to you know, think about six weeks, and you sort of look and, "Oh god, they've been on this for a long long time" and consider reducing it (8:12,1-10,20-25).

7.1.4.1 (a) Analgesia

Pathology in ICU patients causes pain as well as procedures that doctors and nurses do. Nurses can become desensitised to the amount of pain these patients feel or they can associate lower conscious levels with the inability to feel pain (Dracup 1988).

However, pain is highly stressful and although it may not be eliminated, it should be treated (Ballard 1981; Coyer, Wheeler et al. 2007; Helms and Barone 2008).

Robyne linked physical causes of pain to analgesic dose, when I'm working with someone who's paralysed, if they're a head injury patient, they're on at least about 3 or 4 mls of morphine an hour via an infusion, that's like, if it was 2, I'd be thinking, "Oh, maybe that's not enough, you know, oh, don't know about that." If its multiple fractures and stuff like that, I'd be more edging toward the five. And those times when they are lighter and they're not paralysed and you're doing things with them you can see sort of where you're at, you know, a little bit. (3:8, 12-22)

We accounted for things we did to these patients that caused pain.

Patrick gave them a bit of morph before you do dressings like that. But then we don't sort of do that for turns and stuff like that. (5:15,23-25)

Administering analgesia also has unwanted side effects. While using narcotics to relieve pain we may unwittingly be causing the discomfort of nausea or constipation. Pain can keep patients awake resulting in sleep deprivation, however, giving opioid

analgesia also disrupts normal sleep cycles by decreasing REM [rapid eye movement] sleep (Kido 1991; Parker 1995).

Assuming that narcotics are the best pain treatment options results in us thinking that the comfort options that nurses are in control of are not as effective.

7.1.4.1 (b) Sedation

Benzodiazepines are quite lipid soluble, so the fat distribution of a patient should help determine dose. Midazolam is highly protein bound, so low patient serum albumin can increase availability of unbound drug (Clark, Fontaine et al. 1994). Benzodiazepines tend to suppress slow wave sleep (Tanner 1987). A daily interruption of sedation has been suggested to be of benefit in the reduction of time patients are ventilated (Helms and Barone 2008).

Again, we determined our administration of sedation on effect; we aimed for a sleeping patient. An added benefit of sedation was to make our job easier; sedated patients were easier to ventilate and they lay still.

Patrick knew sometimes we give them a bit of the midaz too. I guess it just makes it a little bit easier for us as well... I can think of instances where you say, "I'll just give this patient some midazolam so he can get some sleep," but I think also you're very relieved when once they are asleep. (5:11,1-8) I've known people to criticise that thinking and over a period of a shift it can have its positive aspects as well... If you look at the whole say, ten hours, especially if you think of night shift, I think its a big impact on what happens in the morning. (5:11,17-22) I think we're fairly human in that. (5:11,27) (You don't have to be so watchful I suppose, or so next to be bed if they're going to injure themselves.) Yeah, or watch their hands (Yeah, so I suppose well that's got lots of issues in it and its got comfort issues as well as safety and giving the nurse a break.) (5:11,10-15)

It has been recommended to reduce anxiolytics slowly (Clark, Fontaine et al. 1994), however, in our unit at times they are ceased outright.

Robyne had a problem with the neuro cases because quite often they'll [the doctors] say, "I want all sedation ceased so that we can reassess them." And I know that's necessary, but, you know, that's a compromise they're waking up, they're gonna maybe be in pain, but we have to assess their neurological status. (3:9,22-27)

7.1.4.2 Touch

ICU patients have reported the most significant sensory deprivation was of caring touch (MacKellaig 1986). Touch is a fundamental human need. Failure to thrive infants improve with therapeutic touch in the form of loving and cuddling (Powell, Brasel et al. 1967). If nurses use touch in a soothing and comforting way, this will move the primacy

of the sympathetic stress response to a parasympathetic one which in turn will aid healing (Field 2000). Bergbom-Engberg and Haljamae (1993) found nurses considered it was easier to touch children, old people and dying patients, rather than adolescents and patients their own age. Nurses have to also be careful as western society is a low touch one and the patient may find touch unpleasant, especially older men (Green 1994; Dyer 1995). However, in the ICU environment, touch can become unpleasant when it is only associated with tasks and procedures (Bernay-Roman 1994).

Turnock (1989) found that the priority of physiological needs of these patients resulted in an emphasis on ICU nurses performing tasks. Task touch stresses getting things done (Morse 1992), whereas expressive touch can provide support and reassurance (Stanton 1991; Dyer 1995). Most nursing touch is for tasks because of the amount of technology in ICU (Pearce 1988). The ICU environment can also cause fear in nurses, especially new to ICU, and they cope by focusing on coordinating the technology and avoiding communication with patients (Leathart 1994). However, nurses use task touch to also make patients look their best in addition to coordinating technology to aid recovery (Benner, Tanner et al. 1996).

7.1.4.2 (a) Position

We positioned these patients in bed.

Rhea thought position would have to be the most important because they can't tell me and that's something we can see and do something about. (8:2,23-25) **So she looked** while we're positioning the patient well obviously we look at, does it look comfortable to start? Or in alignment? Which is the normal position for limbs and things like that and we're always pretty good about supporting with pillows and using extra blankets and things like that, checking to see that they're not lying on parts of the equipment and stuff. You sort of picture yourself in that position, if you were lying in the bed in a position that looked uncomfortable, would you lie like that when you're trying to sleep? (8:2,1-12)

I position the patient in a way that looks comfortable to me, taking into consideration their tissue injury, eg not lying on incisions or drains or pieces of ICU equipment. (Nbview.doc:2,8-10)

Patrick made sure that their head is in a comfortable position, that their back is nice and aligned so they don't sort of get too much back pain from those awful mattresses, and also a pillow between their knees (5:3,5-9) fluff up the pillows (5:24,9)

Rhea pull that pillow round a wee bit more just to support under the neck. (8:29,33-35)

I usually turn the pillow over and pull it down to their shoulder and put the tubes, lines, drains etc into some sort of order and not tight. (Nbview.doc:2,22-24)

Ballard (1981) suggests proper position with body alignment with frequent change. Positioning of a patient in side-lying is suggested to optimise sleep (Parker 1995).

Even though we thought these patients looked comfortable, Patrick had some insight into the real comfort of our standard positions,

I was talking to someone the other day and they went to bed themselves and positioned themselves as a patient, the way we position our patients, and they said that that wasn't really all that comfortable. (5:2,26-30)

Patients are often positioned for chest physiotherapy or pressure relief, however, very few people actually lie or sleep in the positions nurses place patients (Dyer 1995).

Patrick thought nurses in the unit were stuck in their practice of placing these patients in traditional routine positions. When a patient was placed in an unusual position for ventilation rather than comfort, Patrick gained insight as to the possibility of alternatives to tradition.

I think you're limited to our really narrow boundaries, as in patient left right on their side... we get locked in to this automatic pilot often and I think it prevents us from exploring other things. I had a patient and she was at the stage where she just couldn't communicate whether she was in pain or not; morph midazolam infusion was off because of the renal function and all that, and not out of comfort, but because this was one of the last things we were going to try, because her lungs were really bad, we turned her on her stomach and she looked heaps more comfortable than when we put her on her left or right... she was just turned right over and rather than having the pillow behind her back, had a pillow in front... a couple of pillows and the tube, and, I mean, she looked really comfortable, it was like one arm up and, "Oh," you know "Why don't we sort of do this more often," and I think that we could be a little bit more pro-active but then I think people are probably a little bit afraid of what the reaction is (5:9,11-10,2)

Patrick also understood the vulnerability of change in terms of the reaction of others who prefer to remain in status quo.

Doering (1993) suggests nurses consider haemodynamic consequences of positioning patients in addition to skin integrity and comfort. She talks about there not being significant differences in cardiac output and pulmonary pressures measured on backrest of supine to 60 degrees elevation. Measurement of right heart pressures vary with sidelying. Oxygenation varies with sidelying, with better oxygenation obtained when the diseased lung is down.

7.1.4.2 (b)Turning

We frequently changed these patients position.

*I cited the physiological reason *The routine in the unit is to turn the patient from side to side second hourly and only on their backs for washes and doctor's rounds. I generally follow this because leaving a patient [not turning them second hourly] might allow them more rest and less pain temporarily, but disrupted skin integrity or lung pathology would cause greater problems later. This type of patient is completely in my**

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control, so I have to be aware of all their body parts and attachments when they are moved. (Nbview.doc:2,11-18)

Whereas Patrick thought of comfort, the difficulty of this is that everybody has that most comfortable sleeping positions and you just can't communicate that with them at that time, so you just assume that by switching them over every couple of hours, at one point you'll have them in a comfortable position for at least two hours (5:3,10-15)

Bryce wasn't so sure that probability would overcome individuality, we think yeah, sure, we're making them comfortable rolling them from side to side, but does that person really sleep on side to side, they might sleep on their stomach and just solely their back (4:3,22-25)

Because of its frequency and routine nature, at times it was easy for us to minimise the impact of changing these patients' position. Patrick thought it was because of the lack of response from the patient I guess you try not to, but I think that if your patient is conscious and the eyes are open I think you tend to turn a little bit more, I don't know, to try and be just that degree more gentle, because you can actually visualise that, you can see the pain, whereas, I guess, with the very unconscious, you think 'cause they aren't able to show their pain... I don't know. Sometimes I notice that when you get help with turns and stuff on nights...sort of, the old heave ho! (5:6,8-20)

I thought knowledge levels might contribute, *usually the wardsperson helps turn patients (or more if the patient is very large), and it is an issue that some wardspeople are rougher than others...* (Nbview.doc:2,18-21)

Maybe tutorial sessions could involve staff members, including wardspeople, in the position of a patient in bed, blindfolded, while other staff position and turn them. This would enable increased awareness of what these patients may be experiencing, of course, without the pathology that caused them to be in ICU.

7.1.4.2 (c) Hygiene

Ballard (1981) considers mouth care a comfort option. Mouth care was appreciated by patients who remembered the dryness and discomfort of oral mucosa when intubated (Heath 1989). ICU patients have nothing to taste, so mouthwashes can be refreshing from the point of view of sensory stimuli (Dyer 1995). We cleaned these patients thinking of what it was like to be clean ourselves.

Patrick thought having their mouth cleaned very often. I think that's a very big part of being comfortable. Having that awful taste out of your mouth, whether they could realise that at the time or not (5:3,17-21)

I agreed *often I suction the mouth after every tube suction, but clean it with mouthwash second to fourth hourly and do a proper scrub with toothbrush and paste when I wash the patient. (Nbview:2,26-28)*

Patrick thought extras we could add to the routine bed bath wash would help these patients be more comfortable.

I guess that's another comfort issue is the wash in the morning (5:11,28-30) I think sometimes its a little bit forgotten as well just little things like shaves and hair washing and stuff, I don't think that's done enough either. (5:12,3-6) I think that's probably very difficult to visualise for like say, female nurses, but like a shave in the morning, is just like, its beautiful. You feel alive again, and its nothing like getting out of the shower and having a good shave and, so its like there'd be no way I wouldn't shave somebody in the morning. I mean, unless you can't expose them or something because its too cold or something its one of my sort of things is a guy's got to have a shave (5:11,30-12,3)

I knew what it was like to have clean hair *imagine what you'd feel like if you had your hair washed, I mean even though they're in bed and its not like having a shower, but at least you'd feel slightly more clean.* (5:12,8-11) In the literature, one patient mentioned her appreciation of hair washes (Clarke 1985).

There were small but not insignificant touch measures which were not included in the literature I had access to.

Patrick also considered, like the eyes, you know, not sort of clagged up all the time, I think that's a big part of comfort. (5:3,23-24) *Their eyes could need hourly to fourth hourly washing with saline and drops or ointment.* (Nbview:2,28-29) Patrick continued, like just wiping someone's forehead or head with a warm damp cloth every so often I think that does a lot for them. (5:3,24-27) *Depending on how sweaty they are, I may have a wet cloth hanging by the bed to wipe their face and forehead whenever I walk by the bed.* (Nbview:2,29-31)

Including relatives in some of the comfort measures helps them feel involved and valuable, and may be useful as a coping strategy (Aguilera 1990; Woolley 1990).

One night duty, Asha involved a dying patient's wife in his care. I had that man in bed one and his wife helped me wash him at the end of the night... (2:13,15-17)

7.1.4.2 (d) Massage

Joachim (1983) claims massage decreases the requirements for pain and sleep medication. Richards (1994) found back massage promoted sleep in elderly men with cardiovascular disease in a critical care unit. She suggests that back massage is not often done by critical care nurses because of a lack of time, however, she claims it would take as much time to administer a sedative drug. Waldman (1993) warns massage by an untrained practitioner on patients who are sedated and paralysed could lead to injury. Although Dunn (1990) claims there are no deleterious effects on physiology. Nevertheless, massage as a treatment modality should be done by a

trained person, preferably with a medical background. If nurses wish to use massage in their practice, they should complete training in this area in order to maintain their professional conduct (Hill 1993; Waldman, Tseng et al. 1993).

Rhea felt doing a bit of massage and just a back rub, I'm tempted to say that sometimes its not practical... because of maybe certain conditions and position and stuff like that, but also if they can't tell us, there's absolutely no way, what's the point in rubbing their feet, is that going to solve their headache, you know, or sore ribs, their sore tummy? We don't know where their pain is, I mean, we can say, maybe sort of say, "OK, right they've got a head injury, sore head." you know, they've got a flail chest, OK, when they're taking deep breaths, but in what case would you sit and rub their feet? I mean, like I can understand and I would spend hours and I know yes, I'd rather sit down too, but like Gillian Barré you know, they can't tell you, and you know that they're sore and they're stiff and the greatest relief to them is if you stood all night and rubbed their hands and feet and just did passive movements with them, and I have done that for them, but I can't.. (*Because there's no connection there's nobody that's said, "Because I've had this abdo surgery and it hurts and you've given me morphine and its made it a bit better but if you rub my feet it would be heaps better," There's nobody that's said that so that you..*) I know a lot of people whose beds are damn hard and if you rolled them over and rubbed the small of their back I'm sure they'd just be in heaven but is it going to stop the surgical pain that they have or the headache that they have or... I don't know if its of benefit... I would say I wouldn't be, I wouldn't go gung-ho about it,(8:24,2-25,10)

Maybe the usefulness of touch had more to do with our skill.

Rhea, I'm sure if you were in one of the Asian countries they would say, look, do a body massage as you're having your bed bath to an unconscious patient, would be you know, so much beneficial to them and relaxing and all the rest,(8:26,1-5)

Ballard(1981) suggests the use of back rubs for comfort. Back rubs of one minute duration were studied because it was thought that it was closer to clinical practice than massage. The researchers found that a back rub was mildly stimulating rather than relaxing (Tyler, Winslow et al. 1990). Physiological relaxation has been found to take 10 minutes of massage (Sims 1986).

Patrick, imagining himself as a patient, thought sometimes you try and give them a bit of a back rub and that sort of thing (5:3,29-30) or like being at the hairdresser, you're lying back and your head's .. and give you a nice massage, very nice. (5:12,14-16)

In critically ill patients, body areas available to be massaged may be restricted with lines and attachments. Foot massage has been found to be beneficial to the whole patient (Martin 1990).

Asha told of an incident where she had observed touch to the feet of a critically ill patient had a positive effect. He's the sickest person I've seen live. Amazing that he did. He was on like

100% [oxygen] for three weeks. He's amazing, but his sister used to come in every day and do, what do you call it when they rub their feet? (*Like reflexology*) Yeah, reflexology on him. A friend at work told her that it might work and so she had this little map of a foot, she'd say, "What's wrong with him today?" and we'd say, "His liver's off a bit." and she'd rub his liver section, but she sat for hours rubbing his feet and that's when he fell asleep. (2:16,15-25)

7.1.4.3 Talk

When patients cannot communicate or are incapable of seeing, hearing or understanding, they are unable to present themselves as people. Sometimes it seems that nurses and others do not consider the patient as a person, for example, discussing of patients between staff within earshot of patients, not warning the patient of suctioning until halfway through procedure or referring to patients as their disease state (Turnock 1989; Halm and Alpen 1993; Dyer 1995; Dyer 1995). Patients then feel isolated and depersonalised (Dyer 1995). Nurses may work on a false assumption that patients with impaired conscious level are not as aware or are unable to hear so nurses are less likely to communicate with them (Leathart 1994). However, lack of response does not always mean lack of awareness (Dyer 1995). In previous studies, we have seen that some seemingly unconscious patients can hear and do remember. Talk to unresponsive patients was shown to often include the patient's first name, was louder and structured in short sentences. Comatosed patients often remember this talk (Morse 1992). Turnock (1989) revealed that nurses found it difficult to talk to unresponsive patients. Evaluation of talk as an intervention is difficult when the patient is unresponsive (Hagland 1995). Yet we should talk to comatosed patients "because they may hear, because some comatose patients may get better, and because we are caring professionals." (Puma, Schiedermaier et al. 1988, p22).

7.1.4.3 (a) Comfort talk

Nurses help to humanise the ICU environment (Rushton 1991; Sheen and Oates 2005). Effective communication with these patients occurs when nurses help them to make sense of the frightening and unfamiliar ICU environment (Hagland 1995). Comfort talk includes maintaining normality in the face of seriousness, which helps decrease distress, and because it makes it feel safe for the patient (Turnock 1989; Morse 1992; Magarey and McCutcheon 2005). Lawler (1991) uses the term *minifisms* to describe those times when nurses minimise the size, significance or severity of an event involving a patient in order to limit a patient's distress. One way nurses coped with thinking patients in their care are experiencing pain involved minimising the painful aspect of our nursing procedures both when talking with patients and in our own view of our work. Nurses should provide orientating information frequently; to time, place,

illness, progress (Turnock 1989; Dyer 1995), as well as normal conversation about what is happening in the world outside (Dyer 1995). Bergbom-Engberg and Haljamae (1993) found that unless the nurse knew the patient, they found it difficult to talk about general and personal things. The presence of worried relatives resulted in nurses feeling they were less able to communicate with the patients.

Pamela Minden (2005) investigated the effect of words on the experience of pain. The way we use words is important. Minden supports the concept of language describing as well as constructing reality. Referring to hypnosis and also words spoken during surgery affecting post operative pain, Minden recommends that nurses make spoken suggestions of comfort, both in techniques to promote comfort and in the actual state of being, rather than suggesting pain. In addition to the content, patients have also commented on the tone of voice nurses use as comforting (Sheen and Oates 2005).

7.1.4.3 (b) Preparatory talk

ICU nurses like to be busy but this sometimes gets in the way of talking to the patients because there is a culture of looking busy being more acceptable than talking to the patients (Leathart 1994). Some studies have found that nurses in ICU prioritise physical care of the patient over psychological care, because of the serious nature of the patients' illness, because of nurses stress (Ashworth 1987) and because of the difficulty in communicating with these patients (Bergbom-Engberg and Haljamae 1993). The actual communication was found to be more task and nurse orientated than patient centred (Turnock 1989). Bergbom-Engberg and Haljamae (1993) found that nurses, in their initial contact with unresponsive patients, used talk as though the patients were awake. Content was usually associated with nursing activities and preparation for procedures. Talk which is preparatory for nursing procedures has been thought to decrease distress, anxiety, pain and may even help to reduce complications by enhancing coping (Johnson 1972; Asbury 1985; Christman, Kirchhoff et al. 1992). A previous patient who is also a nurse suggests that nurses should explain (Ruiz 1993). The pre-procedure explanation should include information on what will happen in the procedure as well as what sensations the patient may experience, based on what other patients have described (Christman, Kirchhoff et al. 1992). This preparation should also be given to sedated patients (Asbury 1985; Stanton 1991).

Asha told of an incident that happened to a friend of hers who was a patient in ICU. My friend was actually in a very bad car accident when she was younger and she was in an ICU, and she remembers a certain level of consciousness, and I think this is important to know too, and I always think its a pity our

patients don't come back and give us feedback on their time in ICU, but she said she was still having sleep/wake cycles, though obviously nobody noticed, you know, she must have still had her eyes closed or whatever. And she said she remembered one time waking up with this excruciating feeling in her hand, and it was enough to open her eyes and they were doing, I don't know, a stab for blood gases or putting in an IV or something, some sort of needle in her hand. She said nobody'd tried to wake her and tell her, nobody warned her it was coming, they just did it, and she said it was a terrible feeling, and then she remembers a commotion afterwards so she must have put up her blood pressure or something... Many times when I've orientated new staff to ICU, and when you're teaching them to do things like suction or, blood gases, we used to do our own blood gas stabs, give injections, all sorts of things, and saying to new staff, "Now tell the patient what you're going to do." (2:8,5-28)

Pre-operative visits would have helped us know these patients better and would have helped patients be prepared and thus more comfortable with ICU happenings.

Leticia thought we could have patients come down and see the unit so that when they came around post-op they could see, you know, have a bit of understanding about what they were going to experience (1:10, 36-11,2) its like everything, the fear of the unknown is an incredible thing so if you've got no idea, at least if you wake up you feel this thing in the back of your throat, you might somehow think this is the tube they were talking about. I mean, maybe there's a connection, maybe there isn't, I guess you don't know, the individual will respond differently. So maybe if one in ten was helped by it we should make a greater effort to do it (1:11,10-18)

Dyer (1995) (pap354) suggests that pre-operative visits would help the patient to be familiar with the ICU environment and gain information about expected events during their ICU stay. It would also give nurses the opportunity to gain information about the patient in an effort to 'know' the patient rather than see a depersonalised disease process when an admission comes from theatre.

7.1.4.4 Sleep

Nurses have a responsibility to provide an environment with minimal sensory monotony or overload (Stanton 1991). ICU patients are disturbed frequently, so it is important for nurses to review interruptions to sleep at night and for unnecessary monitoring of observations and group nursing activities, omitting non-essential care and timing essential care to leave 90 minute cycles for sleep (Ballard 1981; Tanner 1987; Dracup 1988; Kido 1991; Stanton 1991; Richards 1994; Dyer 1995). Sleep deprivation can cause decrease in body temperature regulation, changes in cardiovascular and respiratory function, muscle control and hormones (Hodgson 1991). Lack of sleep can also decrease patients' immune function (Friese 2008). Also disorientation to time, place, person and self progressing to psychotic behaviour (Kido 1991).

Suggestions for increasing sleep in ICU patients include: lower noise, day and night light levels, sleep inducing medication, reducing sleep inhibiting medication,

uninterrupted time, orientation of patients, synchrony with ventilation, relaxation techniques, massage, music and hypnosis (Friese 2008).

We spent most of our shift doing many activities for these patients.

Leticia suggested better timing of nursing care could have aided their comfort, *sometimes I think that I'm not so good at concentrating my activities to a certain, like trying to concentrate them at one point in the hour, instead of taking the whole hour to do all these things and continually going back to the patient and disturbing them (1:4,4-8)*

Asha was able to waive the second hourly turn protocol when she assessed it was more important for her patient to sleep. You know, [patient's name] who we had for months, he was most comfortable on his left side. Now I'd turn him for pressure care, if I had him on nights, but I'd leave him on his left side for a few hours 'cause if he was asleep, he's comfortable and he wasn't sedated so you certainly knew if he was comfortable or not. (2:3,31-36)

7.1.4.5 Alternative therapies

7.1.4.5 (a) Aromatherapy

Because of her knowledge, Rhea thought aromatherapy was a possibility to promote comfort.

I'm all for getting scents, essential oils and stuff, in the unit 'cause I think the ones that calm the senses and stuff like that would just be so beneficial, especially for the sleep deprivation, (8:26,5-10)

Aromatherapy is the use of essential oils, either as a massage or inhalation. The aroma is received by the olfactory receptors which stimulate the limbic system resulting in change of mood. Waldman et al (1993) state endorphins are also released which helps the patient to better deal with pain, although Hirsch's (2001) claims the evidence is inconclusive as to whether aromatherapy acts like a drug with neurotransmitters or just provides hedonic pleasure. Nevertheless, in critically ill patients, the sense of smell may be distorted by the presence of the endotracheal tube (Dyer 1995). Aromatherapy should only be instituted by a trained aromatherapist, preferably with a medical background (Waldman, Tseng et al. 1993). Alternative therapies should be exposed to the same research as medical therapies using reliable clinical trials (Waldman, Tseng et al. 1993; Green 1994).

7.1.4.5 (b) Imagery/music

Imagery is a talk option which we did not talk about in this study. The relaxation resulting from the use of imagery has benefits such as decreased heart rate, respiratory rate, blood pressure, and peace of mind (Heath 1992; Tiernan 1994). It has been used in critical care areas but not in relation to unresponsive patients.

Music, as another auditory sensory option, has been found to assist relaxation, decrease anxiety and reduce pain by providing distraction. Music goes into the brain via the thalamus and reticular activating system up to the cerebrum affecting imagination, intellect and memory and down to the autonomic nervous system. As music affects predominantly the right side of the brain, endorphins are released by the pituitary, helping with pain tolerance (O'Sullivan 1991; Mynchenberg and Dungan 1995). Although, the tempo, and whether the listener finds the music acceptable or holds personal association with it, will affect the response to it (Biley 1992).

7.1.5 About a way to decrease uncertainty by making the patients more awake

At the time of gathering information from participants, our unit did not often use epidural forms of analgesia. Some participants spoke about the advantages they perceived basing their information on previous experience from other places.

Toni I think epidurals are quite good for pain relief for triple A's [abdominal aortic aneurysm] and things, 'cause you can sort of get them up and mobilise them quite quickly. *(And we don't have them much)* We don't use them enough, I don't think. I know that some of our doctors don't like them very much, but I've seen them used quite a bit, especially with triple A's and other sorts of big abdominal surgery and lots of gyne and things, they use epidurals. I mean they're really great, you know. And I think some people don't really understand them very well, like they try and give them boluses of morph and things whereas they should be turning up the epidural and those sorts of things. *(Do they use them, for the triple A's, do they use them like from theatre onwards?)* From theatre onwards. So when you're weaning them and things to get them extubated the.. early the next morning, first day post op, 'cause then they'll actually breathe up better, they'll do their deep breathing things, they can actually get up and walk around, whereas, often if they're on morph and midaz they're a bit bombed out. They don't tend to sort of respond as quickly. Suppose its just different. *(Different ways of doing things)* (6:p2,8-33)

If nurses are unable to provide comfort or alleviate pain, the response was frustration and anguish (Benner, Tanner et al. 1996). Nurses' response to uncertainty will be further discussed in section 7.3.

7.1.6 Summary

I held several assumptions about intensive care patients; that they are so sick as to be nearly dead but that they want to recover and that we have the ability to rescue them. Resulting from these assumptions is the priority to save life and in order to save life we must be vigilant to changes in physical functioning and invasive in our therapies. The sickness causes pain because of the disruption to normal body processes. The immobility causes pain because of pressure to body areas and stiffness to joints. The invasive therapies cause pain by virtue of their invasion into the body of the patient and by continuing to dwell within the body, they complicate movement. The need for vigilance often causes us to inflict pain in the process of measuring and prevents us obliterating physical responsiveness through over-use of pharmacological analgesia and sedation. How much is 'too much'?

This study highlights a particular nursing situation where defining pain according to patient reports is inadequate. We do not know what unresponsive ICU patients are experiencing while they are unresponsive; neither do we know their expectations and wishes for what should happen in this situation nor their usual manner of responding. Unresponsive patients are like a blank slate. The ideas from this study include: pain is imagining what it would be like if I was the patient, pain is what previous patients in similar circumstances have told me, dying is painful, comfort is lying still, not sweating and having a normal blood pressure. Concepts of pain and comfort are not static. This section covered how these nurses understood pain, how they responded to pain and provided comfort.

Section 7.2 presents information about nurses knowing, learning and their thoughts about the pain care of unresponsive ICU patients.

I have chosen to repeat Figure 6.1.1 of a dialectical narrative situatedness schema from **Chapter 6: Interlude** at this point in order for the reader to visually locate the relevant quadrants of the schema that will be used to direct the discussion throughout the remaining sections of **Chapter 7: Synthesis**.

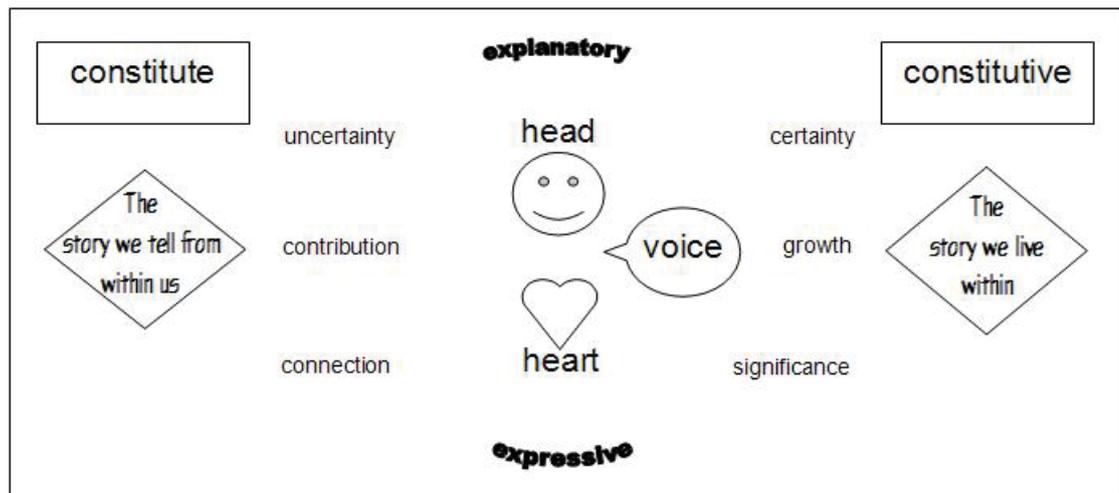


Figure 6.1.1 A dialectical narrative situatedness schema (repeated from section 6.1)

7.2 Epistemology – ‘thinking’ through uncertainty

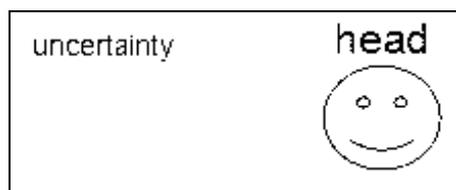


Figure 7.2.1 Uncertainty in ‘knowing’

To varying degrees we all experience and hold in tension both the need for certainty or consistency and the need for uncertainty or variety. Although the nature of ICU provides high levels of both certainty and uncertainty, nurses in ICU tend to enjoy controlling the uncertainty through extensive monitoring of variables. In respect to pain experienced by unresponsive patients, there is no objective measurement option. So, in the immediacy interacting with unresponsive patients, nurses cannot know patients pain for sure regardless of how much knowledge and experience we have. We are aware of actions we take and factors that influence our assessment of pain in these patients, but we still cannot know definitively what they may be experiencing. Being presented with all that we do know as well as acknowledging that it is impossible to be certain will facilitate nurses to be kinder to themselves and to be more considered in their response to these patients.

Patients’ memories of their ICU experience point to pain being a significant factor yet there is not an objective measure of pain for nurses to use with those patients who are

unable to communicate. The uncertainty nurses felt led to some suggestions for inventing objective pain measuring devices. However, needing to work in the current era before such technologies are discovered, nurses use the knowledge within themselves to make an educated guess about the possible pain of their patients.

Nurses come under the nursing tenet of valuing personhood and holistic knowledge but work within an ICU environment that values technology and case knowledge. This section presents ‘knowing’ as a synthesis from nurses’ words, the literature and my understanding of approaching and ameliorating uncertainty. Being trapped in uncertainty may delay taking action and so the various options of instruction, guidelines, experience and self-reflection are ways that nurses can use to become more certain or at least take action despite the uncertainty that exists. The concept of intuition also was raised by participants. ‘Knowing the patient’ assists intuitive assessment, and intuition as a way of assessment is a necessary part of this nursing situation.

Although my colleagues wanted empirical measures for pain, the understanding of the dialectic of stories having ‘constitute’ and ‘constitutive’ properties, and presenting the dialogue between both positions, led to the formation of complex knowledge around the pain care of unresponsive ICU patients. It is our strength as nurses to work with complexity as evidenced in our co-ordination of the needs of patients. Rational knowledge is what is shared with the public; at conferences and in the nursing literature, whereas practical knowledge, based on nursing experience, is more likely to be shared in tearooms (Lumby, 1991). Differences found in prioritising different types and sources of knowledge are a cause of frustration for nurses and leads to miscommunication between doctors and nurses. Sharing of stories allows for an integration of new knowledge while attending to the complexity of nursing practice.

In section 7.2 I will cover the concepts of ‘the darkness’ and ‘filling our satchels’ from the dark room metaphor. So that the thought content can be easily read without distraction from the oral form of expression, quotes from the transcripts have been ‘cleaned’ [notations reflecting speech removed].

7.2.1 About nurses’ uncertainty in relation to pain [the darkness]

Patrick “Do you want to have pain or do you want to be dead?” (5:10,18)

What is pain in unresponsive patients? How much pain is acceptable? How much narcotic is acceptable? Is pain the cost of surviving or not? How are death and pain connected? All these questions add to the uncertainty we work within. Not knowing the experience of pain in unresponsive patients leaves us with the option of guessing that they are situated somewhere between death and extreme pain. Looking at the extreme position of death shows that sometimes it is good to die when suffering is ended and there is peace at last but more often in ICU death is a bad outcome because life is seen as valuable. For us uncertainty surrounds whether unresponsive patients want to recover or die.

When nurses hold the opposing notion of patients' pain being good it shows the price of recovery. Being in pain means that there is still life and recovery is possible whereas the same pain viewed negatively might mean living torture. Our uncertainty lies in what pain unresponsive patients experience and what level of pain they are willing to endure. ICU is inherently a painful place but there are divergent ideas on what level of pain is acceptable; recovery at all costs at one end of the spectrum and at the other end as much narcotic as possible because ICU is a safe place where we can ventilate patients. As a result of the environment of rescue, the bodily disintegration, the high possibility of pain and the context of crisis for the family, ICU nurses need strong coping strategies [coping is further discussed in the next section 7.3]. Pulling us to the extremes of this dichotomy is our desire for life without pain.

Although some nurses seemed intent on searching for a way of finding out patients' pain, others seemed less concerned that they did not know for sure and more content that they were providing an adequate level of pain care for unresponsive patients.

Petra I think generally though we're pretty good at managing people's pain (10:8,33-34)

7.2.1.1 The concept of uncertainty

Variation and inconsistency in practice has been attributed to uncertainty (French, 2006). Therefore ensuring quality of care involves looking at how uncertainty impacts our care and evaluating strategies to become more certain (Thompson & Dowding, 2001). Despite the work from medicine on uncertainty, there has not been a lot of nursing work published on how nurses experience and work within uncertainty (H. S. Kim, 2000). Uncertainty like anxiety cannot be 'killed', it can only be lived within (West & West, 2002). Uncertainty is about ambiguity, complexity, unpredictability, probability, information availability and perception of the individual's own knowledge (Babrow, Hines, & Kasch, 2000). The highest uncertainty occurs when the probability is half and

half (Brashers, 2001), however, uncertainty is experienced rather than analysed by practitioners (Penrod, 2007).

Lipshitz and Strauss (1997) present three types of uncertainty and the ways people use to become more certain:

1. inadequate understanding - reduction
2. incomplete information – assumption based reasoning
3. undifferentiated alternatives – weighing pros and cons.

This study involves Lipshitz and Strauss’s second type of uncertainty where information about patients’ pain experience was incomplete and nurses used assumption based reasoning on which to base their nursing actions. However, French (2006) found nurses had difficulty articulating the information needs relating to areas of uncertainty they were experiencing. Helping to form the question behind nurses’ uncertainty is the first step to finding the answer (Johnston & Fineout-Overholt, 2005).

Recent terminology of ‘not-knowing’ or ‘unknowing’ have been associated with the concept of uncertainty (Anderson-Nathe, 2008; O’Connell, 2000). More work needs to be undertaken in relation to uncertainty and nurses’ decision-making in terms of: how nurses navigate uncertainty now, what motivates information seeking behaviour and what could be put in place for nurses to reduce uncertainty (Cranley, Doran, Tourangeau, Kushniruk, & Nagle, 2009).

Observing variation in nurses’ responses to uncertainty led me to consider a link between the personality of nurses and their ‘need to know’. The availability of detailed and invasive information about patients in ICU may attract the type of personality that requires understanding. Alternatively, the attraction of ICU to nurses may be the technology, the crisis nature of the work or the level of control over patient variables they can adjust to assist recovery. ICU nurses have admitted to liking the intensity of the work (Zalumas, 1995). Because ICU nurses tend to base their work on objective physical measurements they work within the tension of using more the knowledge types of medicine than those considered to be traditionally nursing. Ideas arose in my mind for others to research. Does ICU attract a certain personality? Is there a personality type that likes certainty? Is there a personality type that is at ease with uncertainty? Are there times when certainty or uncertainty are desired? Does wanting certainty link to focussing on case knowledge? Does my personality strive for more certainty than the average? Is that why I did this study? If a large proportion of ICU nurses fall into one type of personality is holistic care possible?

If ICU nurses tend to have controlling personality styles they would be likely to want power over the environment, patients' physiology and their interactions with others. A lack of control would lead to stress and anxiety. Coping with working in an unknowable situation would lead to steps aimed at trying to re-establish control. Being busy and changeable by virtue of the instability of the medical conditions of patients, ICU needs to be a controlled physical environment with everything in its place and staff knowing the exact location of supplies and equipment so that no time is lost in treating patients whose lives depend on quick responses.

Nurses with a controlling personality style would feel comfortable with medical cases that they had seen before and so were familiar to them, with enough information to make decisions, being up to date with their tasks and the patients alive and comfortable. Conversely, unfamiliar medical cases, lack of information, being behind in tasks and working with unstable patients in pain would result in feelings of being out of control.

Lying outside nurses' control area are situations of uncertainty where we cannot know for sure what is happening in the patient. For people with a controlling personality style this results in a negative emotional state. Two ways of coping with uncertainty that have been put forward by Richard Sorrentino and Christopher Roney (2000) are to resolve or avoid uncertainty. People who are relatively comfortable dealing with uncertainty [uncertainty-oriented] try to resolve it whereas other people who prefer familiar or known things [certainty-oriented] may try to avoid uncertainty.

Nurses who value knowledge and beliefs that are more traditionally 'nursing' might stay working within the environment of ICU but try to cope with the tension inherent in the emphasis on physical recovery by behaving outside the cultural norms. Examples of a more traditionally nursing stance would be a focus on 'knowing the patient' which would be demonstrated in how nurses direct their efforts. On the other hand, if individual nurses feel more comfortable with holistic knowledge and care, they may lessen the tension by leaving ICU and moving to another area of work as a nurse [external change] or adapt to the environment of rescue in ICU by changing the type of knowledge they value [internal change].

7.2.2 About the expectation of certainty

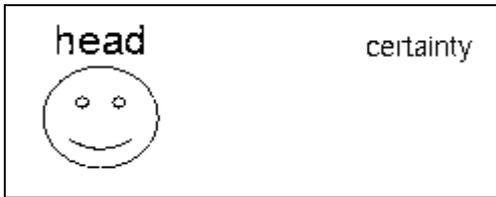


Figure 7.2.2 Certainty in ‘knowing’

It seems reasonable to expect a consistent acceptable standard of nursing care in order to ensure patients receive good quality care and are not harmed. From requiring a minimum level of education for registration of practitioners to publications of ethical instructions, the nursing profession seeks to maintain the certainty of nurses’ competence. Within ICU there are specialty courses, conferences and in-service training to sustain the necessary level of knowledge.

Leticia thought more in-service education would help I think lots of education around the place is a good thing, and I think that we don’t get much, like we’re taught about what the drugs do and how they work, but we’re not really taught how to use them, I don’t think. (1:4,29-33) This was a big guy and I would’ve thought, well, he’s a bigger man he’ll need more pain relief, because we’re used to painful procedures coming through the unit where their abdomen’s opened and chests are opened, and stuff, like that, and so maybe education in those sorts of things is where it would be more helpful rather than how to use the drug, a bit more about how to expect the patient to respond or something.(1:13,30-37)

Relatives certainly expect us ‘know’ and to be certain of our care.

Taylor told of the awkwardness of being asked questions without having answers and still the questions are, “What’s going to happen next?” and, you know, “Are they going to survive?” and stuff like that and its stuff that you just can’t answer (*Yeah, and they want to know*) and you just try and refer it to the doctor. But I just find those questions quite hard and not being that experienced either, you just palm it off onto someone else. Its the best way. (9:6,1-10)

The tension between the uncertainty inherent in assessing unresponsive patients’ pain levels and the requirement of certainty in our practice may motivate us to acquire knowledge by listening to the instructive voices or share our knowledge by telling how it is for us. Of course we do both. When we listen to lectures and conference presentations, read journal articles and follow guidelines then we are growing and learning to live within what others have determined to be our role [constitutive]. When we make our own assessment and advocate for patients in order to contribute to the collaborative approach of care then we are making our insights count [constitute].

7.2.3 About gaining certainty through learning [filling our satchels]

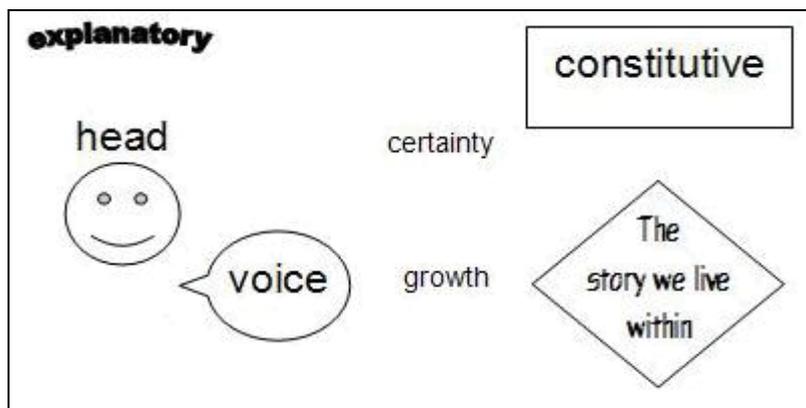


Figure 7.2.3 Growing more certain in ‘knowing’

Striving to find certainty meant that nurses either turned to the knowledge structures they lived within to expand their understanding around pain or permitted themselves to be externally guided in their actions. Nurses would have liked certainty from external sources in the form of accurate pain measurement devices, instructions on what pain responses to expect in patients and information on the pharmacological action of the drugs we used. Particularly in response to me asking the participants how they acquired their knowledge about pain, nurses spoke about the external sources they have already accessed to gain knowledge. Nurses learnt about pain from experience, remembering previous patients, observing nursing role models and through formal learning. I added my thoughts in relation to ways of gaining pain knowledge from research.

“...when we, as nurses, enter a nursing practice situation, we bring knowledge from our life-long learning experiences as well as the structure knowledge of the discipline that we have learned through education and training” (Chinn & Jacobs, 1986, p2).

7.2.3.1 Accurate pain measurement

In order to move towards certainty, nurses mainly operating with case knowledge would look for and value physical measurements of pain. Some of these would be increased heart rate, increased blood pressure, sweating and grimacing [discussed previously in sub-section 7.1.2.1 on pain assessment], although there are not many and each may be contaminated by other pathophysiology.

Rhea tachycardia for any other unexplained reason and a rise in blood pressure for any other unexplained reason that you can't think (8:6,17-19)

Robyne they've got that like grimacing and they always say, "Oh its just the uraemia. (3:12,33-34)

Participants spoke about their hopes for future objective ways to measure pain.

Patrick offered, maybe we could have just like a little BSL [blood sugar level] with an endorphin sort of easy test. (5:23,6-7) **But he conceded** I guess its difficult because everybody experiences it differently. *(Even if they could measure it whether the actual experience is, cause its to do with perception as well)* and it would change from day to day, and sometimes you'd have a really positive day and you can sort of put up with these things, sometimes you just go.. *(Yeah, so we continue to guess)* (5:23,13-20)

I didn't think *there is an answer, unless somebody does some medical research and finds some chemical or neuro transmission or something that equals pain. And then it would be measured like an arterial line measures blood pressure, but I don't think that they will* (3:15,3-10)

Cerebral evoked potentials have been tried but do not correlate with subjective reports of pain (Chulder & Dong, 1983). Possibly chemical neurotransmitters make the pain phenomenon too complex (McQuillen, 1991). To date there is no objective pain measure (Herr et al., 2006).

Robyne suggested statistically averaging awake patients' experiences of similar pathophysiology. Maybe, it'd take a hell of a lot of research, you'd have to invent a computer software package to do it, and get everyone's statistics from every operation and get them to say, "Oh how much pain did you experience?", at different stages and somehow come up with this thing in the end which says, OK, you had a carotid endarterectomy, you should be experiencing this certain.. you know and then like is that applicable? I don't know. (3:14,14-24)

Another option to feel more certain would be to gain knowledge about other nursing actions on which we might focus our attention and efforts - those actions aimed at moving the patient along towards recovery. Knowing that patients' physical systems are being supported or are recovering helps us to cope with not knowing if the patient is in pain. When ICU nurses focus on reversing pathophysiology the outcomes to their efforts are measurable. The clarity of laboratory results is far easier than wondering about an unseen experience.

Patrick I guess you're biggest concern in intensive care when they're sort of really critically ill is their medical side of things, and I think to me that sort of needs to take precedent because I don't know, sort of they go off so quickly. (5:10,6-10)

All the other things in ICU grab the nurse's attention, so if the patient isn't obviously in pain, it may go unnoticed.

Toni I think at times often it might tend to get overlooked as well, because you often think, you know, perhaps your patient is OK, although, I tend to judge, like if I'm turning them and things, you know, if they're grimacing or sort of could appear uncomfortable you can sort of judge that they are in pain. (6:1,21-26)

7.2.3.2 The place of guidelines

In order to alleviate my uncertainty I sought further information and understanding of the situation of nursing unresponsive patients' pain. Instruction is the safety-net for nurses who do not yet have an adequate understanding of the complexity of issues around pain. When nurses use instruction instead of applying their mind to the problem of pain, their levels of responsibility and autonomy are reduced. Nurses may receive instruction from doctors, however, doctors place emphasis on different perspectives towards patients and may not be privy to the width of patient observation information as nurses. Nurses may make their own instructions in the form of guidelines, however, the variability of patients and nurses and the complexity of pain problems does not easily lend itself to formulae. I believe the sharing of information allows for greater understanding and thus the scope to be more thoughtfully responsive in pain care.

Guidelines for the dispensing of this care would be beneficial for novice practitioners who need context-free rules to guide their behaviour because they have no experience. Advanced beginners can recognise overall global characteristics from previous experiences and apply them to this situation, but advanced beginners still need to operate on general guidelines because they cannot yet sort out priorities. Competent nurses begin to see their actions directed towards long term goals. The plan enables prioritising and organising. Proficient nurses see the situation as a whole rather than as aspects and maxims guide practice. They can see when a situation does not go according to what they expect. Expert nurses are not guided by rules, guidelines or maxims, but can intuitively zero in on the problem and the most beneficial actions to be taken (Benner, 1984).

Information seeking by nurses in order to become certain has been found to be mainly directed towards their colleagues or guidelines because the source is accessible and timely; the information is concise and pre-processed (Doran et al., 2007).

Leticia spoke about the pain and sedation chart [see Appendix O]. I wondered the place of charts in terms of practice reminders. Does filling out a form make the nurse more aware?

7.2.3.3 Learning from experience

Nursing practice is devalued when theoretical and abstract knowledge is given more worth than practice. Practical knowledge is the result of repeated experience with patients and causes nurses to see the particular rather than the typical, to give

individualised rather than standard care, and to anticipate rather than only respond to change (Benner & Wrubel, 1989).

We had nursed for varying lengths of time, in diverse practice settings, and had experienced dissimilar personal experiences. As human beings and as nurses, we were very different from each other.

Petra saw herself as a *sort of a mixture of what you've been taught and what you've experienced along the way.* (10:4,33-35)

Bryce thought practice *depended on where you've worked and what kind of patients you've worked with* (4:9,7-9)

Gadamer (1975) defines experience as more than the passing of time, rather a gaining of new understandings and refining of thoughts and beliefs through encountering many situations. Nurses as individuals encounter numerous different situations, both in their nursing practice and in their personal lives. Each circumstance is an opportunity to gain insights. Experiences from personal lives and nursing both give nurses a basis on which to decide about pain in unresponsive patients. In fact, Davitz and Davitz (1980) found that nurses rated patients pain to be similar to personal pain that they had experienced themselves.

When we care for awake patients with similar pathology and are exposed to patients' memories after their stay in ICU, we do not consciously store away these happenings for future reference. Rather, we will pull out those happenings and revere them at a later time when facing a problem for which an happening sheds light or is helpful. Our beliefs about what it is possible for this unresponsive patient to experience are formed through such reflecting on practice. We are taught that assessment of pain can only be done accurately by the person experiencing that pain and so when their view is unavailable we tend to generalise even though we know that what we're assessing is individual. Encountering problems and gaining insights creates experience rather than just time passing. Intuition may be based on a stored accumulation of such happenings. Lumby (1991) claims that learning from and reflecting on practice are essential ingredients of intelligent, informed care. When a situation has been encountered over time, nurses know tacitly or through intuition [further discussion on 'knowing the patient' in sub-section 7.2.3.7 and intuition in sub-section 7.2.3.8].

Remembering previous patients helped nurses to connect with possible experiences of these patients. The nurses generalised using this information and grouped patients by pathophysiology as well as socially or culturally.

Taylor cared for an awake lady who had undergone an oesophago-gastrectomy and was experiencing extreme pain at the intercostal catheter sites. I asked (*so do you think that might influence you somewhat later stage to do that to somebody that's not 'with it'?*) Yeah, I think, it could, which I don't know if that's a good thing because that person's another individual that mightn't feel the pain or might have different levels of pain, so still, I think you've got to assess the individual pain. But yeah I definitely would, now I've done that procedure before and that person was in tremendous pain so this person would have to be in a bit of pain, I'd at least think like that. (9:22,1-16)

In this example Taylor showed how nurses add to their knowledge from their practice, and use this knowledge to inform future practice, but remembering that each situation is unique.

Insight gained from practice help nurses move through the stages of the Dreyfus model of skill acquisition, from novice to expert (Dreyfus & Dreyfus, 1986). However, the acquisition of new understanding depends on readiness to learn, and intellectual ability. Some nurses, although experienced in years of practice, do not portray the understanding and skills of those classified as experts (Benner, 1984; Benner, Tanner, & Chelsa, 1996).

Situations need to create a problem for the practitioner in order for them to be used to gain insights. Schon (1983) claims that unique and uncertain situations, where present knowledge is inadequate, will prompt the practitioner to reflect on practice and attempt to understand it.

If common sense recognises knowing-in-action, it also recognises that we sometimes think about what we are doing. Phrases like ‘thinking on your feet’, ‘keeping your wits about you’ suggest not only that we can think about doing but that we can think about doing something while we do it...Much reflection-in-action hinges on the experience of surprise. When intuitive, spontaneous performance yields nothing more than the results expected for it, then we tend not to think about it. But when intuitive performance leads to surprises, pleasing and promising or unwanted, we may respond by reflection-in-action...Such reflection tends to focus interactively on the outcomes of the action, the action itself, and the intuitive knowing implicit in the action. (Schon, 1983, pp55-56)

Practice is learnt in practice and that rigour in practice is tested by responsiveness and responsibility to the particular situation encountered (Benner, 1984; Benner et al., 1996; Usher & Bryant, 1989).

Toni had seen a range of patients in pain and what worked to relieve their pain while she worked in an emergency department.

Toni I think the way I look at pain has come through experience in different situations, people with pain. Like when I used to work in emergency, people normally came in in a very acute phase, and then in contrast, you always get your chronic, long term back pain and those sorts of things, and I think, just being able to recognise, this person's obviously in acute pain and see what type of analgesia works compared to chronic long term people and when we used to get oncology patients in you could see the huge doses they used to get at home and then you know that obviously it's not working when they still come in in pain and uncomfortable. So, I think just sort of getting quite a broad look at different ways people manage pain (6:5,10-21)

Bryce you look at patients that you've looked after in the past and how they've reacted to similar situations, and I guess, depending on where you've worked and what kind of patients you've worked with, I think you can often pick people who've worked with oncology patients especially, where they're on large dose analgesia as compared to just the medical ward or something like that, where people aren't as tolerant of narcotics especially. And you're talking about giving someone oh I mean, just huge doses of say morphine or whatever to try and quell pain, and you can see that a person who's had that experience is quite willing to give a large dose but on the other hand be cautious about giving a large dose and giving it to the person when they know that they are in that pain enough to tolerate such a large dose. (4:9,5-20)

When Patrick discussed his use of spanco mattresses [soft mattress overlays for the prevention of pressure sores], he seemed to give more weight to observation and listening to those who could personally evaluate the comfort spancos provided than the theory that these mattresses prevent skin degeneration.

Patrick From reports of people being on those mattresses for any length of time, they're sort of not the most comfortable, which, I don't know, I guess we're trying to get better, but I guess those spanco mattresses, although they're good for the skin, I'm not quite sure whether they're too good for the back, because, I mean, they sag and sort of fold up underneath you and have lumps here and there (5:3,30-37)

Most impact was gained when previous ICU patients reported their memories of experiences occurring while in a non-purposive state; the nurses listened and used this knowledge to connect with the present patients. One nurse remembered a previous ICU patient speaking at a conference about the experience of being suctioned.

Rhea he said it was like the living air had been sucked out of him. You know when you cough and you have something caught in your throat and you cough and cough and you just have to try and catch your breath, but you knew it was going to happen, he was describing it as a fact that you'd sucked every last drop out of him and he just felt that he was never going to get a breath because the suction catheter had taken up everything, you know, and so if you think you're doing that every hour or more frequently on the patient, I mean, they must be just exhausted, you know, the mental anguish you go through at the same time and you think that with this and you can't catch your breath, you know, it would be horrible. 'Cause I mean your basic, your basic instincts are that you breathe, breathe, breathe and you just can't do it, it must be horrible. But yeah, I have remembered that. (8:28,20-37)

Hearing patients memories of ICU made us aware how easy it was for nurses to minimise the impact of routine procedures on patients. Further discussion on

minimisation was presented previously as one of our nursing actions within sub-section 7.1.4.3 ‘talk’.

7.2.3.4 Learning from role models

Nurses can learn by imitating role models. Forrest (1989) found that nurses revered instructors who taught students to be caring and provided a role model of caring behaviours. Benner and Wrubel (1989) showed that beginners imitated co-workers as a way of learning caring behaviours.

I told Taylor I can remember when I first started there [in the unit] a more senior nurse just talking to the relatives like.. and I said, “Oh, that’s a good role model, I’ll have to listen to what she says.” (9:6,14-17)

Asha’s instructor for her post graduate intensive care course was a role model of caring. I believe I had a very good clinical teacher when I did my course and he was a hospital trained nurse as well and he’d been nursing for a long time, a good fifteen years or something and he was very comfortable with ICU patients and he communicated really well with them, he always took time to talk to them, it was good to see somebody who nursed an ICU patient, a patient, not nursed the ICU equipment, and I guess we all learn by example and that’s very important and I remember if he came on and saw us, you know, if the first thing we didn’t do was go up and talk to the patient when we came on we were in big trouble. (2:5,6-17)

Asha related observing a colleague who she considered well able to provide comfort. I remember one of the girls in my critical care course, beautiful girl, really lovely, and she’s one of those girls, you know, we all used to say if you were ever sick, the first person you’d have look after you would be M, she was just wonderful, and I remember the charge nurse, well one of the girls, the associate charge nurses in coronary care was really big on having everything clean and tidy around you’re bed and she came up to M once and she said, “M you’re environment is a mess.” and M looked at her and said, “Ah yes, but my patient looks wonderful.” And they did, you know, and Y couldn’t say anything because she was right, you know, so what, she’d get time to clean up her bed area but her patient did, they were clean, they were comfortable, they were happy, but they’re the important things, yeah its little things like that happening that are important. (2:7,15-31)

7.2.3.5 Learning from formal education

In this study, we spoke mainly of practical knowledge gained during our nursing practice, in addition to personal knowledge gained just by living our lives. We referred to, but did not emphasise, some formal theoretical knowledge. Within practical professions, theory and practice are thought to be interactive, both informing each other (Schon, 1983). Theory makes sense of experience or allows experience to be used to better advantage by helping nurses in planning and anticipating for practice situations. Practice never accurately mirrors theory because practice situations hold much more complexity than theory can predict (Benner, 1984). Knowledge that comes from practice and that can be utilised by practitioners may evolve from a dialogue between nurses, patients and academics (Bevis & Clayton, 1988; Lumby, 1991). The theory practice ‘gap’ refers to the rigour versus relevance problem and has been

addressed by looking at how theory can be communicated more effectively to practitioners or finding ways of implementing theory more effectively in practice situations (Usher & Bryant, 1989). Academic dialogue may not reflect what happens at the bedside. As literature talks to itself, clinical nurses may find it irrelevant to their daily work.

This practice-centred knowledge is essentially different to the knowledge deemed appropriate for an ‘evidence base’ for practice. Practical knowledge helps nurses to individualise their care (Benner & Wrubel, 1989). Different practice situations call for different types of knowledge.

Diers (2004) categorises knowledge into three areas: liberal arts, science and nursing. Criticising how these areas of knowledge are covered in nursing education, Diers says the liberal arts such as philosophy might be best left to later in the curriculum, science needs to be more comprehensive, and the nursing thinking around practice is best learned practically. Planning or discussing nursing practice can be left to tutorials or conferences. Diers claims all three types of knowledge are basic to nursing.

One method of classification of types of nursing knowledge from Liaschenko and Fisher (1999) – ‘person knowledge’ of personal intents, purposes, wishes and relationships, ‘patient knowledge’ of the interface between how this person fits into the health care system, and ‘case knowledge’ of pathophysiology and treatments. The picture we imagine in regards to unresponsive patients’ pain is based on a combination of all three types of knowledge but this complex knowledge is put onto a background that is ‘us’ – a formation of knowledge and experience made up over time.

Doctors and nurses draw more heavily on different types of knowledge and have different genres of background experience and knowledge, that is why we often build different pictures in our head and are then in conflict. Considering the three types of knowledge when making decisions would enable better communication between health professionals as to the possibilities of what the patient is going through while recovering and somehow find a reasonable path to tread between pain and death.

Reliance on the certainty of case knowledge was shown when doctors believed that grimacing evident in a liver failure patient resulted from a high level of urea in the blood. The doctors would not allow analgesia to be given. The nurses tried to understand the logic but did not have enough information even though they also looked

at case knowledge. The difference lay more in the goals towards which doctors and nurses were striving.

Robyne and I talked about uraemia and grimacing, ...they've got that like grimacing, and they [the doctors] always say, "Oh its just the uraema," you know... Its supposed to be quite painful, isn't it, just the uraemic state. *(Yes, apparently, just to touch somebody. Its associated with fitting, high uraemia. But I don't know whether that means as it gets lower it would be twitching, but I still don't think that twitching equals grimacing)* Why does uraemia cause pain? *(Its something to do with the skin, I don't know, I'd have to look it up)* I remember people have said that to me to, as well, "Oh, its just the uraemic state, don't worry about it." (3:12,32-13,28)

My dilemma was that *I'm not convinced that grimacing is not pain and when they're not on anything and you can't give anything when they grimace and that sort of concerns me a lot. But I guess I haven't really learnt about if you give somebody with liver failure some morphine, and the metabolites are running around their body what is that actually doing, is that making the liver worse or is it just that they're going to be asleep for longer afterwards, and if that's the case then why can't we stop the pain now, because they must be experiencing torture if they can't have [narcotic analgesia] you know, sort of tossed it all up and think, "Oh, what am I doing here?"*(5:14,15-27)

Seizure disorders are complications of end-stage renal disease and are usually caused by low levels of calcium or high levels of uraemia. Facial grimacing in hypocalcaemia can be evoked by tapping the facial nerve (Munoz, 2008; Schrier, 2006). The metabolites of morphine and midazolam may cause prolonged sedation in renal failure (Irwin & Rippe, 2008).

Person knowledge relates to this individual and is what is unknown and therefore sought more in trying to understand what they might be experiencing. Changing patient allocations makes it difficult for us to get at that person knowledge but it helps us to cope, especially those of us who would prefer to leave responsibility to the doctors.

When nurses understand a situation, there tends to be a combination of theoretical knowledge and practical knowing (MacLeod, 1993). "Clinicians, combining practical wisdom derived from experience and an understanding of an individual patient's situation together with knowledge derived from research, can make sound clinical judgements to benefit a given patient" (Lindquist, Robert, & Treat, 1990, p402). The variety between individual learning journeys of nurses has resulted in a diverse range of experience and knowledge. How do different levels of experience and knowledge impact on pain care? Would standardising experience and education be of benefit?

Our formal education covered both hospital based and tertiary preparatory nursing courses, with some nurses having completed or were current students of post graduate intensive care nursing courses. The history of nursing education, both formal and in the workplace, curiously seems to follow Bines & Watson's (1992) three models of professional education:

1. apprenticeship - focus on professional requirements and competencies, training on the job [*hospital based training*]
2. technocratic - knowledge base, applied to practice, supervised practice in workplace [*during the initial stages of tertiary nursing education*]
3. post-technocratic - professional competencies through experience of practice and systematic 'reflection on practice' [*current ideal*]

The history of subordination, and learning through apprenticeship, contributed to nurses passing on tradition orally, solving problems on the job, and a general respect for experience instead of scholarship (Melosh, 1982). Nursing's transition to professionalisation through use of the rational model, aimed to base the majority of learning on scientific knowledge. However, theory driven practice has not adequately addressed the uniqueness and humanness of nursing situations. The third model closely resembles the process through which Benner (1984) claims nurses become experts.

An alternative perspective from the findings of this study in respect to Bines and Watson's model is that all three forms of education can occur simultaneously in nursing. ICU nurses are expected to exhibit a measurable level of skill competency that usually has been learnt at work, know pathophysiologies and the rationale of treatment modalities and yet also reflect on their own practice adding thoughtful responses to current situations to the body of knowledge that will be applied to future nursing interactions. In this study we learnt on the job when we were instructed by nurses with more expertise than ourselves or we followed role models, we sought out scientific knowledge on the pharmacological action of narcotics and anxiolytics to inform our clinical judgment and we thoughtfully considered our own practice and passed on our reflection orally.

Toni learnt about pain relief measure through formal education a few lectures with like pain management teams and things, which is always very interesting and there's so many different ways you can control pain, like just doing femoral blocks for legs and those sorts of things, just gives you a bit of a broader idea as to what sort of things they can do, you know. Like there's lots of ways you can give pain relief without necessarily just having a morphine drip running, (6:5,21-27)

Nursing is a generalised profession even within specialties and so there is an expectation for nurses to keep up with an increasing volume of knowledge. This knowledge explosion can cause nurses to be fearful of not knowing enough and thereby making mistakes because they did not have the latest knowledge. Despite high workloads, nurses need continuing education (Benner & Wrubel, 1989).

Talking of narcotic analgesia, Leticia thought *maybe education in those sorts of things is where it would be more helpful rather than how to use the drug, a bit more about how to expect the patient to respond or something. (1:13,35-14,1) but she conceded oh how could you teach someone? Cause I guess in a way its so experientially based, like you need to see, and a patient on one mg of morphine might be almost unconscious and somebody else on five mg might be climbing out of the bed (1:5,4-8)*

Leticia thought education about how to expect the patient to respond would be helpful but realises how difficult this would be to teach.

Herron and Reason (1997) have devised a way at categorising four ways of subjective 'knowing'. Extending their participatory inquiry model, Herron and Reason propose that the we involve ourselves in the 'known' and contemplate the relationships between the different levels of subjective knowledge so as to be aware and not constrained in our 'knowing'. Experiential is the first level involving experience of the 'known' at a face-to-face encounter – we see the unresponsive critically ill patient. Presentational is the second level where the 'known' reminds us of an expressive form such as imagery, vocal, verbal – I was reminded of darkness. Propositional is the third level where concepts and theories form – the tension between the subjectivity of pain and the silence of the patient. Practical is the fourth level where we know how to do something – use touch and talk to promote comfort. Herron and Reason used these four ways of 'knowing' to underpin their process of cooperative inquiry where a critical stance led to knowledge that was grounded.

Nurses shared their understanding of pain according to these four ways of 'knowing' within the interviews. The process of considering the linkages between the levels has been a process completed by me as the researcher. In Herron and Reason's work, the participants are involved in the whole process from working out the question to dialogue over the outcomes of the inquiry. The process of this thesis may be viewed as a trial run to a formal space where nurses can together participate in inquiry on pain in unresponsive patients or any other topic they conceive.

Mary Regan and Joan Liaschenko (2008) undertook a study to investigate nursing knowledge that resides below the level of consciousness and found complexity in the

links between beliefs in the clinician, perception of the stimuli, and attributed meaning that motivates clinical action. The specific story elements examined were the protagonists’ intentions/needs/desires, the conflicts/tensions, the actions taken, and the actual or anticipated outcomes. Regan and Liaschenko also noted the language used as an avenue of identifying meaning.

7.2.3.6 Learning from research

The participants did not speak about research informing their practice, possibly because there was little available published nursing research on the topic. However, participants were happy to contribute to my research and they did make suggestions on other research topics that might help pain care of unresponsive patients. What we tended to do instead was what Usher and Bryant (1989) refer to as personal action research, where formal knowledge is used to review practical knowledge. Speaking to each other in understandable ways within this community involves using information provided by research.

Hinshaw, Chance and Atwood (1981) and Chapman (1996) point to the immediacy of clinical decision making and problem solving which does not relate well to research which is slow to do and to implement. This time-lag between knowledge production and use in practice is said to be proportional to distance between creation of theory and position of practitioner. Other reasons nurses may not utilise research in their practice are conflicting findings for some areas of practice, information gaps and resistance to change (MacGuire, 1990). Vratny and Shriver (2007) suggested nurses need role models of how research can be used in the clinical setting and supportive administration in terms of availability of time and money as well as access to journals, databases and the internet.

The nursing profession aims to attain best practice through finding a good ‘evidence base’ for nursing actions (Chapman, 1996; Rycroft-Malone et al., 2004; Titler et al., 1994). The Australian Nurses’ Code of Ethics specifically stated that in order for nursing as a profession to raise its standards of care, nurses must be involved in research (Council, 1993). However, by 2008 the Code of Ethics had been amended to say, “Nurses are responsible for ensuring their decision making is based on contemporary, relevant and well-founded knowledge and information” (Council, 2008, p8). “Research offers the scientific foundation to direct nursing practice toward the delivery of high-quality, cost-effective patient care” (Lindquist et al., 1990, p402). In

fact, Fawcett (1980) and Styles (1982) suggest it is unethical not to base nursing practice on research where research exists and is relevant.

Claimed benefits to the profession include: promotion of nurses' confidence thus enhancing nurses' professional growth and allowing nurses to collaborate with other disciplines, and the provision of optimum patient care in order to improve patient outcomes and thus be more cost effective (Luckenbill Brett, 1989; Pearcey, 1995; Swanson, Albright, Steirn, Schaffner, & Costa, 1992; Tibbles & Sanford, 1994; Titler et al., 1994). Wilson-Barnett, Corner & De Carle (1990) suggest researchers have a responsibility to make their studies clinically relevant; an evaluation of care on which nurses can base practice, rather than 'nurse watching'. It is also claimed that this research on which practice should be based must allow for "...generation of knowledge that is useable in multiple clinical areas and remains stable over numerous testings or replication under diverse practice conditions" (Ada Sue Hinshaw & Smeltzer, 1987, p20). The aim of this scientific research is to provide a theoretical basis for current practice and decision making (Draper, 1996; Funk, Tornquist, & Champagne, 1995; Tibbles & Sanford, 1994).

Research utilisation by clinicians continues to be at a less than desired level for evidence based practice. The barriers to the use of research that clinical nurses have identified include: the complexity of presentation of research reports, the lack of clinical relevancy, the lack of support from the workplace and the preference for a third party to deal with the research and deliver the message to the clinicians (Rycroft-Malone et al., 2004). Research within clinical nursing practice would be likely to ask the most salient questions for the betterment of patient care. The knowledge gained from clinical research is used in the real world of decisions, judgments, and human encounters and can improve patient care if the 'whole' patient is considered in relationship to the environment. Jelinek (1992) understands that clinicians need more than research on which to base their practice because the aims of research and practice differ. Researchers aim to find treatments that are better than average while clinicians want to fix the current problem.

Wilson (1990) acknowledges the need for different types of research within nursing to address different problems. "We recognise that ours is a complex and diversified professional domain. We need rigorous research methodologies that allow us to predict causes and outcomes. But we also need analysis methods that allow us to define, describe, and explain the real practice world of nursing to ourselves and to others"

(p11). Paley (2006) argues that in complex or uncertainty situations, decisions made on evidence are usually better than decisions made on expertise or 'patterns of knowing'. He further warns that the availability and accessibility of 'evidence' potentially makes the lay person the expert.

Usher & Bryant (1989) suggest that practitioner based action research encourages practitioners to be creative and thoughtful. Action based research can help practitioners understand practice and solve immediate problems, as well as recognising structural and ideological constraints that surround and impinge on professional practice. Practitioners' participation and collaboration in reflection about practice empowers them by enabling them to be more informed and responsible in their decision making. Winter (1989) suggests that professionals can learn from their practice using action research as a form of practice which is intrinsically educational.

Reflection-in-action promotes change and as a result is risky; practitioners may feel exposed and vulnerable. Avoidance of risk may cause practitioners to be stuck in routine and habit. Tradition can be self perpetuating; if it has worked before it will be used again (Benner, 1984). Reflection on practice helps nurses to take note of how they respond to ambiguous situations and align their beliefs with their practice (Stilos, Maoura, & Flint, 2007).

The defining attributes of reflective practice are: the substance are problems from practice, the process involves looking at how the past impacts the present and synthesising to the future, and the result is personal change (Duffy, 2007). The ability to be reflective aligns with adult learning theory through deeper understanding of the substance of the reflection and better skill at the process of critical thinking (Cirocco, 2007). Ruth-Sahd (2003) suggests that opening up the theoretical lens of reflection to include a critical look at the ideologies within which we exist would shed more light on practice. Kundrik (2007) advises that nurses' preconceptions need to be identified so that they do not become unconscious barriers to the process of learning.

Asha put together her knowledge of the effect of touch with a concrete practice situation when she cared for a patient who had heart lung transplants, her lungs were stuffed, and she got a shocking heart. It was kept alive on adrenalin so she was never going to live and she was with us for so long, she went into renal failure, liver failure, just everything, total body failure basically, and she never used to sleep. She used to lie wide awake at night, we had her on massive amounts of diprivan [anaesthetic agent used as a low dose infusion for sedation] of a night to try to get her to sleep and I remember one night I got some oil or something and was giving her a foot and calf massage and she fell fast asleep. And I thought, god, you know, like it took a bit of time I guess and effort but it was something good to do (2:16,3-14)

“Clinicians, combining practical wisdom derived from experience and an understanding of an individual patient’s situation together with knowledge derived from research, can make sound clinical judgements to benefit a given patient.” (Lindquist et al., 1990, p402)

7.2.3.7 ‘Knowing the patient’

Pertinent nursing care of patients can be missed in ICU as a result of the crisis nature of the work, through adhering to unit routines, cultures and norms or as a consequence of the individuality of nursing rather than a team approach. Stein-Parbury (1999) in her study on patient confusion in ICU argues for ‘knowing the patient’ as a better way for nurses to assess confused ICU patients. Wilkin and Slevin (2004) found ‘knowing the patient’ depends on the amount of time spent caring for the patient but acknowledge that it was difficult to ‘know’ a critically ill patient. McCabe (2007) claims that nurses are more likely to attend to pain when they know what that pain means for the patient.

I believe that ‘knowing the patient’ aids intuitive assessment and intuition as a way of assessment is a necessary part of this nursing situation. ‘Knowing a patient’ is related to how much time is spent with them (Benner et al., 1996; Jenny & Logan, 1992). As we spent more time with a specific patient, indications of comfort and pain sometimes became clearer, however, in our unit, over-involvement in the nurse-patient relationship was discouraged, as the system of allocation of patient care required differing nurses to care for an individual patient each shift. These patients certainly could not tell the nurses of their experience of pain at the time, however, our eyes saw more than was obvious.

Toni seems at ease with knowing enough about patients’ pain by being with them for a shift. Nurses could be surer of their pain assessment of patients because of the fact that they are there at the bedside more than doctors and not defer to doctors just because doctors control the prescribing of analgesia.

In conversation with Toni I said, *(so as nurses we’re there all of the time, and we can assume things from what the patients have done to them too like how much it would hurt.)* I think you should use your initiative, I suppose a bit more, because you’ve been there 6 to 8 hours and you know how your patient’s been going and you can assess them and I think, get to know your patient a lot better than the people who come around and do their rounds twice a day, ‘cause you’re there, you see the changes and you see what happens when you turn them, and how it affects them, even just their heart rate and those sorts of things, you know, where they start breathing up a bit more, and I think, when the physio’s there if that causes them lots of discomfort and things, *(So as nurses we’re not really probably recognised as much for that continual assessment, whereas the doctors come along and do the five minute assessment type of thing and go by that.)* Yeah, and I think at times they don’t really, take into account that you’ve been there all the time. I think that they should actually try and discuss with you how the patient’s been going, ‘cause, they just come along and say, “Well we’d better stop the sedation or stop the

analgesia or decrease it or something.” You say, and then if you could, if they would just listen to you a bit more I think, ‘cause you’ve been there all day and you know how your patient is and *(why you’ve got them to that state at that time)* to that point, time, yeah, *(what’s happened just before)* yeah, exactly, so I think as nurses we’re not often, given enough credit for being able to ascertain how uncomfortable your patient is or how they’re too comfortable or whether they’re getting too much pain relief or not enough. *(And it’s hard too because, there’s certain things that we can do to make them comfortable, but the ultimate pain relief, analgesia type stuff is all controlled by the medical staff.)* ‘Cause you can only do so much if you’ve got really strict orders as to how much you can give. (6:6,9-7,16)

Sakalys (2006) outline the dialectic nurses face between the objective [physical processes] and subjective body [living person]. Patients come as unknown blank slates; their families come knowing the person of the patient better than anyone but with varying needs for other knowledge. Families can help us to synthesise the dialectic into a more holistic picture. Conceptualising patients as whole integrated entities also helps nurses to bring in the necessary information to help families move to a place where they know their loved one in this context. Nurses can be the character of the story that enables family coping.

The family may know the critically ill person really well but now the family does not know the nature of the family member in the context of ICU. As a result, the family needs new knowledge about this context and we need to value the knowledge they have about the patient. Feeling inadequate in their vast resource of person knowledge about the patient, that is not valued as highly as the medical knowledge of health professionals, creates tensions within family members especially who ask numerous questions to try to cope with their supposed inadequate knowledge and regain some sense of control. Do they not value their own knowledge of the patient or do they not offer it because we do not value what they know?

7.2.3.8 Intuition

Because we live in a Plato based Western society that values rationality, intuition has been undervalued. However, for pain in unresponsive patients, we could not access much logical evidence with which to use the analytical approach, so we often relied on subtleties. Interestingly, even when using intuition, nurses usually checked out their clinical judgment of nurses using a rational approach (Benner & Tanner, 1987; Benner et al., 1996).

Bryce told of how he used his own experience and knowledge together with input from others to help determine what these patients were experiencing. when a person isn't capable of their own actions, you depend very much on other people, including yourself, to try and interpret how they're

feeling, like their physical comfort and especially their pain issues (4:2,28-32) its a difficult area because you can't get a person's verbal responses often, and I guess there's never going to be a way whereby we can truly assess it (4:7,13-16)

Dreyfus and Dreyfus (1986, p28) defined intuition as "...neither wild guessing nor supernatural inspiration, but the sort of ability, explainable in physiological terms, that we use all the time as we go about our everyday tasks." It has also been defined as judgment without rationale that is based on experience, not magic (Benner et al., 1996). Intuition can be a rational process that is inaccessible or the matching of an internal pattern with external events where cues are contextual and relational, (Leners, 1993) or it can be immediate knowledge, seen whole and not arrived at linearly (Rew, 1988). Polanyi (1962) claims clinicians know more than they can tell, and may know more than they can practice. Rew and Barrow (1987) also talk about nurses finding it difficult to articulate the non-quantifiable aspects of their work.

In this study, we were unable to articulate the specifics of our intuition. Bryce thought I guess there are those that can't move at all... its a feeling one I think its not a looking one... you've got to try and start to look at subjective feelings (4:13,11-16) I think there is a gut feeling, and everyone'll say go with your gut instincts, because more than often you're correct in those instincts. (4:14,1-3)

Dreyfus and Dreyfus (1986) describes six aspects of intuition: pattern recognition, similarity recognition, commonsense understanding, skilled know-how, sense of salience, and deliberative rationality. Benner and Tanner (1987) claim that these aspects are not separate but work together to produce intuitive knowing. Nurses see many previous patients in similar situations and the resulting knowledge of patterns of illness and human response has variously been referred to as 'tacit knowing' (Polanyi, 1962), 'skilled know-how' (Benner, 1984), 'knowing in action' (Schon, 1983), 'knowing the particular patient' (Jenks, 1993; Jenny & Logan, 1992; MacLeod, 1993; C. A. Tanner, Benner, Chelsa, & Gordon, 1993). This form of knowledge is only gained through interpersonal relationships with patients (Jenks, 1993). Good clinical judgment is based on 'knowing the patient'. Seeing this situation through previous patients and expected outcomes, allows nurses to pick up on subtle clues that stand out (Benner, 1984; Benner et al., 1996). Seeing the 'big picture' includes more than the clinical picture. The patient's world of future possibilities and anticipated trajectories are added (Benner et al., 1996). There is an idea of synthesis in intuition as opposed to the breaking down to smaller parts that is inherent in analysis (Rew, 1986). Both experience and imagination are necessary for intuition. Imagination leads to creativity (Rew & Barrow, 1987).

Beth seemed to recognise that her intuition was a synthesis which involved pattern recognition together with imagination. I suppose probably just an instinct you get... and it most probably is more an association of the conditions that they're in and would I be feeling pain in that situation. (7:2,16-19)

Patient attributes, how much time is spent with the patient, nurses' expertise and their ability to be empathic by putting themselves in the situation of the patient, impact on 'knowing the patient' (Jenny & Logan, 1992). Pyles and Stern (1983) talk about a nursing gestalt where nurses link their knowledge, past experience, gut feelings, and patient cues into a matrix of impressions. Nurses base their interventions on these impressions. The gestalt is created by perception, experience and intuition.

The time spent with the patient improves the quality of assessment. Nurses are in constant attendance for their shift whereas doctors do rounds twice a day and are called by the nurse if there are problems. When the doctors do the rounds the patients are 'prepared' and are not in the middle of a procedure.

In the conversation with Toni I said, *(I guess for me, its 'cause we're at the bedside all the time so you see what its like for them all the time, whereas the people who are actually imposing that restriction on you sort of come along twice a day, they don't have to be there.)* No, and I think they normally come along just when you've given them a bolus or something, 'cause you've turned them and they think that obviously they've been like that all day. They come just when they're, you know, you've given them that little bit too much of morph and they're asleep, then they say, "Well that's it, no more." You know, and you just think, "Oh, if they were there for 24 hours, they'd know that this person is uncomfortable and is fully with it." but, you know, yeah its hard. *(They're hardly ever there, actually, when you're actually doing turns too, 'cause that's when you inflict, well when the patient would be the most uncomfortable)* (6:3,36-2,3)

Even though intuition is a worthwhile form of nursing judgment, nurses who arrive at an assessment intuitively may not agree because they have come to their practice level through differing experiences. Benner, Tanner and Chelsa (1996) suggest that entering into dialogue with others and re-examining the experiences that have shaped intuition would help nurses to eliminate tunnel vision.

Bryce had experienced asking for advice and receiving conflicting suggestions. if you ask someone's opinion, there can be a difference like three or four mls an hour [morphine infusion] which is a fair bit, I mean, even two mls over 24 hours, I mean, that that's 48 mgs, that's a lot of relief, but that's subjective. Obviously that person either feels that, "No, he hasn't got any pain." or "God, he must be in a lot of pain with that." ... its like doing a multi-choice. I think if you had the one patient and got four people that were on that afternoon, I'd lay a bet that you could a range; if it was sitting there on say five and said, "Do you think he needs more or do you think he needs less?" and if you put a case down, the exact same case to each person, I think you could go from say about, a low of about three, one person saying, "No, I think you could start to wean it

down a bit.”, whereas a person may say, “No, keep it as it is, that’s fine.” and another person saying “No, I think I’d increase it one or two just to see how it goes.” (4:13,24-14,16)

It would have been helpful if reasons had been given for the advice to increase, decrease or leave the rate of the infusion.

What underlies intuition is something within the nurse that allows for insights not based on facts. This cannot be taught. In fact, the more factual information nurses have to know, the less they are able to focus on the patient as a person and use their insight. Good nursing relies on insight. Rew and Barrow (1987) argue that reflexive and creative ways of thinking should be taught to nurses because drawing on past experiences and creatively responding to new experiences are a part of intuition.

From a review of nursing clinical decision making literature, Maggi Banning (2007) located the three current models of decision making in nursing. I had already considered the ‘information processing model’, based on the traditional scientific/medical model, when I was looking at clinical decision making as a possible methodology for this study. I believed information processing was inadequate in reflecting the complexity of nursing unresponsive patients’ pain. I gave more credence to the alternative ‘intuitive model’ but it still didn’t fully cover the complexity that was apparent to me as a clinician. The ‘combination model’ of both in the form of deduction and pattern recognition seems closer aligned to clinical practice and is more contemporary thinking. Some nurses’ thinking processes may follow a diagrammatical pattern but there would be others whose thinking is more complex and variable.

7.2.3.9 Continuity of care

Within our unit, time is not usually available for involvement or close connection as nurses are allocated care of different patients each shift. Administrators consider nurses to be interchangeable and that the care plan will ensure quality care. Morse (1991) claims that in a caring relationship, care givers are not interchangeable; she compares this to counselling where there needs to be consistency. Care-giving breaks down with multiple caregivers (van Hooft, 1987). Kelleher (2006) devised the ‘synergy model’ which aligns nurses and relatives characteristics so that competencies can interact for the best outcome for patients. While the model seems ideal, in the reality of an ICU with rotating rosters, it would be difficult to implement.

‘Knowing the patient’ would be enhanced if there was a rearrangement in the allocation of nursing staff to the care of these patients so that there would be a consistent team of

carers for each patient (Coombs & Ersser, 2004). Primary care, where a team of nurses with differing levels of experience are allocated to an individual patient for the length of their stay, would be an option for nurses to spend more time with patients, thus increasing the time together and knowledge of patients. (May, 1991). Benner (1984) talks about primary nursing reducing fragmentation of nursing care thus making nurses more visible and accountable. If nurses have a group responsibility towards the patient and work together for the betterment of the patient, there is a shift from individual competitiveness. Some nurses may not follow their intuition when a collaborative group approach to decision making is taken, instead they may acquiesce to keep peace (Jenks, 1993). Mutual support can be given by collectively observing patients, preceptoring new nurses by competent ones, and preceptoring competent nurses by experts (Benner et al., 1996). Knowing your peers helps in response to information provided by them (Jenks, 1993). A previous ICU patient who was conscious during her stay, commented that she appreciated the same nurse to look after her (Clarke, 1985).

7.2.3.10 Practice development

There is an expectation that nurses will endeavour to base their practice on the best current evidence so that patients receive consistent quality care and the health system works efficiently and does not waste resources (Pearson, Field, & Jordan, 2007). Rather than trying to find a prescriptive solution to the difficulty of uncertainty, I believe that establishing a supportive process that is ongoing and aimed at making sure nurses' knowledge needs are met, when the evidence is lacking, would be a way to ensure they can nurse well.

Valuing storytelling as a way of moving towards understanding and the creation of a collective story as a means of empowerment of a group leads to ideas around facilitating a 'telling' and 'listening' culture as a way forward in terms of finding the areas of nursing practice that are of immediate concern to the group and also finding 'solutions'. Attending to the complexity of life allows groups involved in storytelling to avoid the trap of quick and simple solutions that may not address core issues or may in fact add to the problem. Allowing clinical nurses to be the key change agents in their own practice development cuts across ideas of those outside the group knowing how change should happen for the group and setting up such change to occur.

7.2.3.11 Voicing

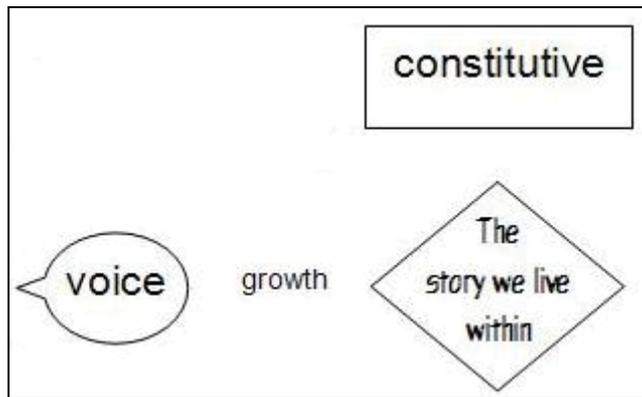


Figure 7.2.4 Growing through listening

The thinking that ICU nurses put into their care of unresponsive patients’ pain is based on different types of knowledge from various sources. Nurses listen to the ‘voice’ of external sources to gain the information and then filter and assimilate from that information what they want to keep. The learning process fulfils the need for nurses to grow. Nurses’ growth in their knowledge should positively impact their practice by reducing the uncertainty.

If the whole diagram was conceptualised in terms of a story, then nurses are the audience to the story coming from the role models, patients’ families, lectures, literature or research. Nurses respond then by ‘telling’ their own story – ‘your theme in my story’. New knowledge comes through the story we live within then is passed on to others through ‘telling’ our story we might be empowered to make a story happen.

7.2.4 About acknowledging uncertainty through sharing

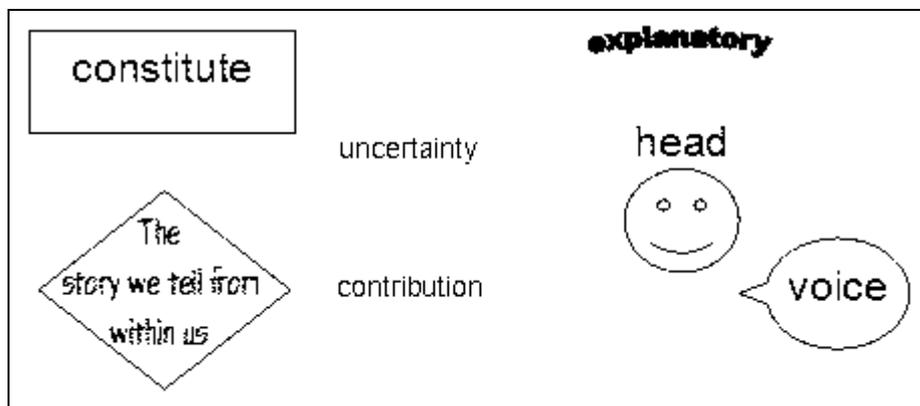


Figure 7.2.5 Contributing our uncertainty in ‘knowing’

Acknowledging uncertainty meant that nurses came to their own decisions about unresponsive patients' pain based on their inner 'knowing' and were internally guided in their pain care actions. Whilst recognising that they were not certain, nurses shared their own determination of patients' pain particularly with doctors in an effort to advocate for patients. Nurses would have liked doctors to add the contribution of nurses' inner understanding of patients' pain towards a collaborative approach in setting the goal of care for patients. Part of the picture of uncertainty comes from the variability in pain assessment and management between nurses and within individual nurses at different times.

We can contribute to understanding through sharing knowledge that is contained within us. Nurses seem to work within this metanarrative of a hierarchy of knowledge where doctors know the most, more experienced nurses know more, less experienced nurses know less, relatives and patients know nothing [or if they do it becomes a problem for us]. Rather than a hierarchy, valuing each person's contribution would engender a culture of dialogue.

7.2.4.1 Decision making

In western society, since the time of Plato, reason and rationality have been valued within decision making, whereas the appropriateness of emotion has been questioned. As a result, decision making research has concentrated on simulation in order to eliminate situational factors so that observation of variations due to experience, education and personality can be identified (Benner et al., 1996; Fonteyn, 1991; Jenny & Logan, 1992; C. Tanner, 1987). However, both reason and emotion are socially constructed and are constitutive (Benner & Tanner, 1987; Benner et al., 1996).

Cognition in terms of knowing and understanding, and emotion have been separated out in the literature, furthermore claiming that understanding needs emotional distance (Ramos, 1992). For sound clinical judgment to take place, disengaged, analytical reasoning by standing back from the situation is assumed to be more reliable than practical engaged reasoning. Rational clinical judgment is based on context free assessment of normal versus abnormal findings to arrive at a diagnosis. For the new nurse it is helpful to stand back when they are flooded with anxiety, and if the patient is unknown, this is where the expert practitioner may start (Benner et al., 1996).

However, experienced nurses are more involved through knowing the whole situation and remembering typical human response patterns. These patterns acquired through

the practical knowledge of clinical experience enable experienced nurses to function with a clinical grasp of the situation. This results in more skilful practice. Expert nurses stand back when the situation feels uneasy in some way or when they lack the right clinical grasp in order to determine what is happening. Nurses use multiple perspectives which improve clinical understanding, reasoning and decision making. Yet, even though 'knowing the patient' is central to care, rational/logical discourse receives higher status (Benner et al., 1996).

In ICU several factors make decision making more difficult: wide range of types of patients and problems, lack of information and time pressure. Instead of decision trees or even evidence-based information, doctors have been shown to use pattern recognition and ruling out worse case scenarios (Freshwater-Turner, Boots, Bowman, Healy, & Klestov, 2007). When uncertain, nurses make decisions by: relying on experience through pattern recognition of cues, conferring with colleagues and taking anticipatory actions [being 'one step ahead'] (Hedberg & Larsson, 2003). Nurses may work within the 'state of unknowing' by reassuring themselves with what is 'known' and reinforcing the 'known' in their activities through checking and putting backup plans in place (O'Connell, 2000). Expert nurses find decision-making in uncertainty more difficult than novices because they are aware of more possibilities in alternative diagnoses and outcomes (Tabak, Bar-Tal, & Cohen-Mansfield, 1996).

Nurses identify with patients by imagining themselves or family members in the same predicament as the patients (Benner, 1984). What nurses imagine is based on their experiences and knowledge.

Rhea showed an understanding that the experience of being intubated involves discomfort. She described feelings she thought these patients would have, I think its important that we realise comfort as well as what you perceive as pain. Physical pain, surgical or whatever, discomfort is going to be just as bad and its going to nag just as much as like a physical pain inside, you know or whatever and we've got to remember that, you know, the tubes just can be as annoying, it won't be because of physical pain but because they're there annoying all the time. Its going to be just as bad as pain and that would be justification for giving them something for comfort (8:26,30-27,2)

Nursing care options may also be based on what has been seen to work before for other patients, or may be just tradition ["we have always done it this way"]. To be able to explain rationale is important for our nursing actions so that tradition is not blindly followed. Nursing practice is much more than tasks when nurses attend to the complexity of patients and tailor their care within a context (Benner et al., 1996). Lawler (1991) claims the best practice of nursing is found in a combination of attending to the

see-able [rational objectivity] as well as the feel-able [experience/intuition]. This complexity is evident, for example, when noting the difference between nursing actions in a cardiac arrest situation of an individual patient with specific needs as opposed to a simulation in a lab setting. 'Knowing the patient' involves knowing their lived body as well as their objective body (Gadow, 1980). If practice is refined in new situations, [Schon's 'reflection in action' (1983)] this can result in superior care that is different to the dead or ritualistic repetition of tradition (Benner et al., 1996).

Bryce entered into 'reflection in action' when he used his memory of similar but awake patients he had nursed to give him a baseline for administering analgesia, then he titrated the dose to any indications from this patient, you look at how you other people have reacted, "OK this person's got similar injuries whether it be from an operation or whether it be from a sustained accident and so the last guy that I gave this amount to he went overboard, maybe I'll just cut that back and go from say half that, and that fits if he's feeling good, then I can give him an a little bit just every now and then to keep him over that." So, you get them to a peak I think, and if you think that peak is verging over the top, then you slacken off a bit and wait till you've come back down a little bit and then start to keep them at the top again or you keep pushing that little bit more to try and get to the desired effect. (4:9,27-10,3)

7.2.4.2 Advocacy

Sometimes doctors seem to give orders and control the availability of medication based on a view of attending to only the relevant patient pathophysiology being treated.

Doctors tend to value logic and case knowledge. If doctors sometimes see patients as malfunctioning physical systems, then patients may be conceptually broken into bits.

The person of patient may be lost when focussing on pathophysiology. Nurses claim to see a more integrated picture of the patient that includes emotional and social aspects as well as physical parts. Nurses then can choose whether to take instruction from doctors and relinquish a measure of their autonomy or, alternatively, to use their knowledge and present their opinion to doctors in order to add to the depth of multi-disciplinary care for patients. I think that an area of potential improvement in nursing practice would be nurses seeking to know and present to the multi-disciplinary team more facets of patients that make the total person.

Toni they'd all sort of say, "Only give him boluses if, you know, desperately required." and those sorts of things, (Why did they say that? Why did they want it, to give the least amount?) Because they wanted to see if he was alert and orientated, 'cause they were worried.. (to assess his head) yeah. But you can see their reasoning behind it but then you can also say, "Well, if he's in pain, you know, he shouldn't have to be lying there in pain when you're turning him and those sorts of things, just to make sure that his neuro status is OK." But its hard I suppose, what's the priority really? (6:3,23-34)

Status seems to be related to distance from the bedside and separation from patients (Campbell-Heider & Pollock, 1987), however, 'knowing the patient' requires proximity to

the bedside and connection with patients. It takes time for nurses to know unresponsive patients, in order to see clues of what they are experiencing. Doctors are not with the patient all day long. They cannot watch everything that happens. Advocacy for unresponsive patients involves nurses speaking on behalf of the patients (Gadow, 1989). Nurses have useful information on how the patient is going that is not available from anyone else (Alpert, Goldman, Kilroy, & Pike, 1992).

Toni said I mean, if you'd had huge abdominal surgery, the last thing you'd want is somebody to be tipping you over every couple of hours, you know, and that's when I think our, we obviously see things.(6:6,1-4)

Our advocacy role extends to other people whose actions impact on patients in our care.

Asha I think we get harassed by other people too, we all do and we do it to people I'm sure, everybody does it, you know when they're trying to turn someone and the patient's just coughing and gagging, sputum's pouring up the tube and, you often say, "Let's stop, suction the patient and we'll go on then." and, the wardy says, "No, come on, come on, I've just got to do this." or x-ray says, "Look, can we just take this x-ray?" and , it takes a bit, I guess its age as well, you know, a bit of maturity and, confidence to say, "No, I'm going to suction the patient." and there's times where I've had to do that and that's the big thing that we're patient advocates. (2:6,15-28)

Giving information about patients to relatives involves different types of ‘knowing’.

Taylor felt sometimes you think you're going to say the wrong thing (*It's just a minefield really, isn't it, because not only have you got lots of different people at lots of different knowledge levels saying different things, but also they're interpreting them all differently as well.*) And sometimes your getting cases that a lot of the relatives, not a lot, but some of them are involved in health professions, like sometimes you get RN's or, we've had a few patients that the relative's have been doctors and, you know, they really watch you when you're doing stuff and they know what you're putting SNP [**sodium nitroprusside**] up for and stuff like that. You just feel like you're getting watched all the time, getting assessed by the relatives. So I suppose there are a lot of different knowledge levels. (*And then what people are prepared to say to relatives are different too. Some people, even though they might know a lot, don't say anything, but anyway it still gets interpreted.*)(9:6,18-7,8)

If patients and their families view doctors of too high status as to be out of reach they will not be able to easily communicate with them, conversely doctors may not treat equally patients and families of low status. Coinciding doctors and family being at the patient's bedside at the same time is a difficulty that may result in frustration and miscommunication when families need information and reassurance and doctors need information for decision making. The difficulty families have in giving and taking information because of the overwhelming nature of crisis adds further to frustrations felt.

7.2.4.3 Collaboration

Story concepts as a way to convey information may have a positive contribution towards doctor/nurse collaboration. To be working together towards a common goal requires communicating in order to settle on what the goal is, communicating what has to be done to achieve the goal and where we are along the way towards the goal so that everyone knows and everyone should contribute to this process (Weissman, 2000).

Doctors have the power to allow or restrict the administration of narcotics and sedation to patients. This study found that we sometimes were unable to use these options to treat what we believed was pain or discomfort because the doctors disagreed with our assessment of patients' level of comfort or pain, or believed restricting these drugs would aid patients' recovery. We then were limited to only using nursing options in our care for these patients which left us believing these patients were not comfortable. Alternative pain therapies were only informally considered as options.

Because I am a nurse and the research information that I am using comes from nurses, looking at the relationship between us and doctors will be presented from our point of view. I did not gather information for this thesis directly from doctors or patients and their families but relied on the available literature to help inform me of others' viewpoints.

Although nursing is now firmly located within tertiary education and has many professional organisations, nursing continues to be seen as a low status job as is evident in ongoing lack of interest in pursuing a nursing career. [Women's work, dirty work, relational rather than technical and 'scientific', low paid.] Operating within a low status means that we are not automatically given respect or listened to with the result that we need to work harder to be heard. We may also not respect ourselves. Nevertheless, even though nursing still holds relatively low professional status, ICU nurses hold high status within nursing.

This attributed status of intensive care nurses has been linked to our use of technology, the crisis nature of our work in terms of rescue, life and death. If our higher status is attached to the nature of ICU work then we may be at risk of valuing the crisis and technological aspects of our work, aligning with medical values over the more human caring aspects that have been traditionally aligned with nursing. Being located at the higher end of status in our profession may lead to admiration and respect from some

yet also belittlement, devaluation or just being ignored by others. Having others see us as having a higher status level than most nurses does not necessarily mean that we take this on board for ourselves. Perceiving our status as low results in less confidence in ourselves in relation to those we perceive to have higher status. So some of us may feel at different times intimidated or confident depending with whom we are interacting, what is happening for us at the time and how we present.

There has been a long history of lack of respect between doctors and nurses in both directions. Especially documented in the nursing literature is a lack of respect from medicine towards nursing based on status, knowledge types, the large number of men in medicine, the predominance of women in nursing and the work being 'women's work'. This history influences the present interaction to the extent that many doctors consider their pain assessment for unresponsive patients to be definitive (Ashley, 1976, 1980; Campbell-Heider & Pollock, 1987; Darbyshire, 1987; Dayton, 1992; Keddy, Jones-Gillis, Jacobs, Burton, & Rogers, 1986; E. Y. H. Kim, 1994; MacKay, Matsuno, & Mulligan, 1991; Marsden, 1990; McMahan, Hoffman, & McGee, 1994; Stein, Watts, & Howell, 1990; Sweet & Norman, 1995; Wyatt & Wyatt, 1994). Nurses' roles in decision making continues to be undervalued (Coombs & Ersser, 2004).

This study showed some evidence of our subservience to doctors.

With regard to drug prescription, Taylor said "Oh well, the doctors ordered that, I shouldn't question that (9:10,32-33)

In relation to nurses initiating and being creative in their care. Patrick said *people are probably a little bit afraid of what the reaction is from the medical side (5:10,1-3) I think we need to sort of continually try and be a little bit more creative, which is not encouraged from the medical side again, either. (5:17,27-30)*

Instead of seeing the relationship as equal, we deferred to the doctors who made decisions which affected our care of these patients.

Beth told of how she plays the doctor/nurse game. *Its, you know, what the doctors say. You have to go along with it otherwise "you're rocking the boat" and upsetting everybody. But, there again, if they're absolutely, well, I'm forgetting that they can't indicate... although if you felt that they were in a lot of pain you'd could like try and get somebody to review the order and assess the patient, but.. (7:7,4-11)*

Collaboration enhances nursing and medical job satisfaction and provides better efficiency in patient care resulting in improved patient outcomes (Alpert et al., 1992; Judith Gedney Baggs, Phelps, & Johnson, 1992; E. Y. H. Kim, 1994; King & Lee, 1994; King, Lee, & Henneman, 1993; Knaus, Draper, Wagner, & Zimmerman, 1986; Mitchell,

Armstrong, Simpson, & Lentz, 1989) "High-quality patient care is dependent on the relationship between care givers: these interdependencies actually define the unit, with the whole becoming greater than its parts." (Marsden, 1990, p423) In order for collaboration to become a reality, there is a need for mutual respect (Benner et al., 1996; Meighan, 1991). Respect depends on how well individual nurses and doctors 'know' each other (Alpert et al., 1992; Jenks, 1993).

Miscommunication between doctors and nurses can occur where nurses use expressive words based on their holistic view of patients [patient knowledge] to report their observations of possible pain and doctors, not hearing clear, objective, observable indications [case knowledge], dismiss any other evidence (Aroskar, 1985; Hov, Hedelin, & Athlin, 2007; Weissman, 2000). This results in frustration on the part of nurses and possible mismanagement of patients' pain because all available relevant information has not been taken into consideration while deciding on a course of action (Stein-Parbury & Liaschenko, 2007). Manojlovich et al (2009) categorised doctor/nurse communication in terms of openness [how easy it is for nurses to speak to doctors], accuracy [factuality of information from doctors to nurses], timeliness [promptness of information from doctors to nurses] and understanding [effectiveness or comprehensiveness of information].

Leticia had been looking after a woman who had malaena and haematemesis, she had been on a sedation infusion [inferred later that this was or included morphine] of about two mls an hour, very small lady, and she had been unrousable on that, or very lightly rousable, she'd open her eyes, just, and that was it, and seemed very comfortable, and they [the doctors] stopped her infusion to wean her ventilation and she was continually grimacing and when I discussed that with them, they said, "Well we don't want to put her back on the morphine infusion because she'll go back to sleep and she has advance liver disease so we can't give her panadol, you know", we just couldn't give her anything and I felt really uncomfortable with that, and I was precepting a new nurse and I said to her, "I find it really difficult because I want the patient to be comfortable and I feel in a way embarrassed by asking because I knew she had advanced liver disease but I hadn't really thought the whole process through before I asked the question I just knew that my patient seemed to be in pain, and so I said, "Well what can I give her?" and he said, "Well you tell me what you can give her?", so then I had to think about all those things and he said, "I don't have an answer, I can't give her anything", so we couldn't and we just had to watch her grimace when we turned her. He felt that she was fairly encephalopic, you know, a bit under anyway so it wasn't going to be that much of a problem, but I still felt uncomfortable and I felt difficult about being with a new nurse who I was trying to teach to be the patient's advocate and recognise when they were in pain. I sort of said, "Well, sometimes you just have to ask the question and be told no, but at least you've asked the question." (1:5, 21-6,12)

Nurses and doctors have been found to have different understandings of a satisfactory relationship; nurses want mutual respect and trust whilst doctors want information, help

and for nurses to be competent (Benner et al., 1996; Prescott & Bowen, 1985; Stein et al., 1990). In this context, joint decision making is said to occur when nurses provide input to doctors who make the decision. Resolution to conflict is either through competition [assertiveness and unco-operativeness] or accommodation [unassertiveness and co-operativeness], not collaboration (Judith G. Baggs & Schmitt, 1988; Kilmann & Thomas, 1977; Prescott & Bowen, 1985). Assertiveness being defined as meeting our own needs and co-operation as meeting the other's needs (Kilmann & Thomas, 1977).

Some doctors may not seek or listen to information from nurses. If doctors disagree with how nurses see a situation, then nurses have the option to go higher in the medical hierarchy (Benner, 1984). Stepping on toes, when nurses proceed up the line of medical authority is something undertaken only when nurses think the way they read a situation will make a big difference to the patient. "When claims for final authority supersede the need for skilful negotiation of clinical knowledge, then both disciplines and the patient are likely to lose" (Benner et al., 1996, p293).

Petra was willing to find the doctor who would agree with her reading of a situation. I mean in that sort of situation I just like discussed it with the doctors and if you didn't get a right answer from one you just went to someone higher up (10:5,32-35)

Nurses have at times been guilty of playing the 'victim' role in relation to doctors. "Victims have no responsibility or authority, they are passive reactors to outside forces with no power over the course of events. Rather than hiding behind this false image, nurses must relinquish the privilege of victimization and confront physicians as professionals." (Moss, 1995, p255) Playing the victim involves criticising rather than taking responsibility (Hardingham, 1994). Sometimes nurses can pass their feelings of frustration down to more junior nursing colleagues (Wyatt & Wyatt, 1994). Instead of waiting for doctors to ask their opinion, nurses should initiate sharing of their clinical judgment by speaking clearly and directly, thus ensuring respect for their knowledge and skills (Dayton, 1992; White, 1989).

Toni reflected a passive stance when talking about how doctors make decisions on their rounds. I think that they should actually try and discuss with you how the patient's been going, 'cause, you know, they just come along and say, "Well we'd better stop the sedation or stop the analgesia or decrease it or something." You say, and then if you could, if they would just listen to you a bit more (6:6,34-7,3)

Skill of negotiation goes through stages similar to novice through to expert. Expert nurses feel responsible for patients and present information to doctors in a format that shows salience and interrelatedness between facts, highlighting the most important

points. They call this ‘making a case’ (Benner et al., 1996, p287). MacKay, Matsuno and Mulligan (1991) found nurses with post-basic qualifications perceived less communication difficulties with doctors. Inexperienced nurses may not present information in a form that doctors expect and thus may not be heard. When nurses and doctors have known each other over time, communication becomes clearer. There is tacit recognition of each other’s abilities (Alpert et al., 1992; Benner et al., 1996). In order for doctors to know the nurses with whom they are working, Mechanic & Aiken (1982) and Fagin (1992) recommend a clear differentiation of nurses with regard to their level of education and experience. The most likely players of the ‘doctor/nurse game’ are experienced nurses and inexperienced doctors. Young doctors are taught they have the ultimate authority and responsibility and perceive more communication problems with nurses than more experienced doctors (Benner et al., 1996; MacKay et al., 1991).

An example follows of assertive advocacy where collaboration was absent. Because nurses spend most time with patients, they sometimes have to deal with caring for patients who appear to be in pain.

Asha dealt with this situation by being assertive. I remember one night having a screaming argument with the registrar in another ICU I worked in, because he just wanted to give a tiny bit of morphine to a paralysed patient and saying, “You have to give them something sedative as well, you know, all the narcotic will do is just make them drowsy. You can’t paralyse someone..” and we paralysed this patient just on a bit of morphine and we just had this screaming tachycardia, went really hypertensive and I just said, “We we’ve got to give them something.” and we were just pouring in the morphine, this was horrible, and we just.. he was a huge big islander boy, and he wasn’t ventilating and, even though he was paralysed, he was just obviously awake under the paralysis and he was just.. it was really horrible to see him, we were trying to get the morphine in and what was happening was, we had the morphine on like a biflow and the morphine must have been running up into our maintenance line. So he wasn’t even getting any morphine. Oh, it was just horrible, and I ended up just getting a syringe, ‘cause I knew he mustn’t have been getting even the morphine, pulling the morphine out of the bag with the syringe and injecting it into another port, so I knew he was getting it, and he settled down eventually. But it was just horrible, you know and medical staff had gone and they just didn’t seem to think it was a problem when we told them about it afterwards, and that’s terrible. (2:8,28-9,16)

The doctors did not have to deal with the fallout of their orders and dismissed the nurse’s view of the situation.

Leticia dealt with her uncomfortable patient by we just had to watch her grimace when we turned her. (1:6,3-4) and was similarly dismissed by the doctor. He felt that she was fairly encephalopic, you know, a bit under anyway, (laugh) so it wasn’t going to be that much of a problem (1:6,4-6)

The literature provides no specific behaviours of collaboration (Alpert et al., 1992; Judith G. Baggs & Schmitt, 1988), however, the qualities of shared planning, decision making, problem solving, with open communication have been delineated (Alt-White, Charns, & Strayer, 1983; Judith Gedney Baggs et al., 1992; Judith G. Baggs & Schmitt, 1988; England, 1986; Hamilton, 1991; King et al., 1993; Lamb & Napadano, 1984; Prescott & Bowen, 1985). Coeling and Wilcox (1991) suggest that collaboration involves the knowledge and skills of different professions combining to synergistically influence the care provided. When nurses and doctors are both competent and understand their different but intertwining roles in patient care, then the two professions will be able to work well together (Eubanks, 1991).

Examples of collaboration did occur when the nurses and doctors had similar goals.

Toni related a situation where nurses and doctors worked together for the comfort of a patient who suffered 40 percent burns...It was mainly torso and face and things, and he was still ventilated at this point in time, and when we used to do his burns dressings, we had an anaesthetic ventilator, so we used to give him an anaesthetic to do his dressings, that was fantastic, he would not flinch or move, 'cause burns dressings, you know how traumatic they are, was like a two hour ordeal, just transferring him into the bath and those sorts of things...when he first came in we weren't very experienced with burns and things and, it was just by chance that one of our registrars had worked in a burns unit somewhere else and said "Well, you know, I think we should do this" The first time we did his dressing, it was just after he came in from cas and he came upstairs and he was just on, you know, a morphine infusion or something and you could tell he was just grimacing in heaps of pain and no matter how many boluses were given it just wasn't effective. And we all got a bit distressed 'cause you could tell that he was in heaps of pain and it wasn't working. So we got him reviewed and that and we decided to get this anaesthetic ventilator. You could put the gas, you could titrate to whatever we thought he needed, you know, you just check, if flicker or twitch or anything you could just increase it and that, and the anaesthetic reg used to stay there with us while we did it and, that was great, like you could do the dressings and he'd be fine, then you'd put him back into his bed or the chair and whatever you were doing and it was really good. You could tell he was obviously in no pain, it was great. I thought that was very good. It was just lucky that they had this reg (6:11,17-12,15)

Having a history of inequality in status and education has brought about tension between doctors and nurses which continues to impact on our ways of going about caring for unresponsive patients in ICU. How does the relationship between doctors and nurses affect pain management? Who has the best sort of knowledge for making decisions about pain in these patients? Who has spent the most time with this patient over their stay? Who is the most articulate or forceful in presenting their view? At this time is the priority recovery or comfort?

The valuable contributions that doctors make to pain management are their knowledge of physiology and pharmacology and their understanding of the overall plan for the patient. Nurses found the power and status of doctors and their heavy emphasis on the goal of physical recovery unhelpful. Our uncertainty surrounding doctors involved questioning the accuracy of their knowledge of this particular patient and whether the importance of patient recovery aligns to the wishes of this patient. Sibbalds et al (2007) suggests that improving communication is an important step towards reducing incidences of ‘futile care’ where considerable resources are used without reasonable hope of satisfactory patient recovery.

Understanding patients as whole people who fill a place in the world and impact on others, then spending a whole shift solely with one patient, results in nurses contributing their holistic outlook to pain management. However, working with different patients each day may limit the depth of our holistic view. Our perceived low status and power levels may inhibit the expression of the knowledge we hold valuable. Uncertainty surrounding nurses lies in what knowledge and experience we can access that relates to this particular patient and how effective our relationship will be.

Doctors and nurses have been educated and socialised into divergent ways of understanding the world and have dissimilar goals to achieve. In relation to this study these differences play out in each profession’s focus towards and beliefs about pain. We want a whole view of patient as person in a context and the ideal that all members of the community can contribute to the journey that the patient undertakes. Respect from all towards all members of the multi-disciplinary team will benefit patients under our care.

7.2.4.4 Voicing

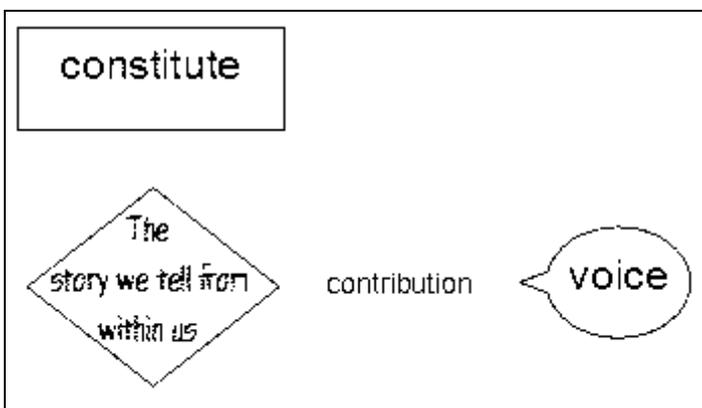


Figure 7.2.6 Contributing though telling

If the whole diagram was conceptualised in terms of a story, then nurses are the tellers of the story about decision making, advocacy and collaboration towards the goal of patient care. Nurses are telling their own story in response to the knowledge they have received. It is their story, which means the information has been processed by them so what they tell is a synthesis – ‘your theme in my story’. New knowledge comes through the story we live within then by ‘telling’ our story we might be empowered to make a story happen. What is voiced comes into another’s ‘head’ in terms of knowledge.

“Telling a story reveals one’s own stance and encourages the practitioner to clarify one’s own responsibility for working toward the patient’s good. The absence of a story seems to indicate a poorly developed sense of agency and connection to the situation. It signals alienation, disengagement, indifference, or *anomie*.” (Benner et al., 1996, p319) [original emphasis] Increasing our public storytelling about the tension between caring and curing would give insights into how this fine line is navigated. Storytelling could show how knowing the patient is more beneficial than breaking down practice to make it more efficient (Benner et al., 1996).

Support comes though the psychological release of expression, of being heard, and thereby meeting our need to contribute (Robbins, 2004).

7.2.5 Summary

Even though section 7.2 is about knowledge, having extensive knowledge about pain does not help find certainty in identifying unresponsive patients’ pain experience. The more knowledge we have regarding pain, the more we know about what cues we are to look out for and what actions we take helps us to believe that we are ‘doing our best’. Valuing the knowledge that is contained inside nurses gives us the confidence to ‘voice’ our opinion on the pain of unresponsive patients so that the information available on which to make patient goal decisions is more complete.

Uncertainty can lead to a discrepancy between what we consider ‘looks’ comfortable and what the patient might actually be experiencing. We remember shocking horror stories from patients who remember pain. How do they cope with suffering? How can we cope with thinking we might be causing pain? Further discussion on living with uncertainty and nurses’ coping strategies will be presented in the next **Synthesis** section 7.3 Ontology – *‘feeling’ within uncertainty*.

7.3 Ontology – *'feeling' within uncertainty*

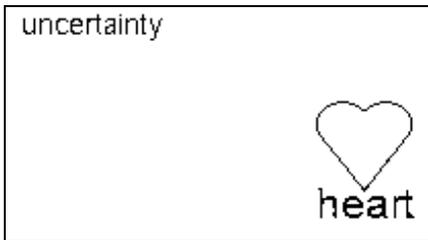


Figure 7.3.1 Uncertainty in 'being'

Nurses work within a story when they care for unresponsive patients' pain. This surrounding story is made up of the imposing environment of ICU, the little that is known from pain literature, mandates from nursing literature about comfort, care, justice and advocacy, a role of observing and thus serving the doctors in terms of being their eyes, doctors taking charge of the course of patient care and having the prescribing rights for ordering analgesia, and nurses serve the hospital in terms of staffing levels and workloads and shiftwork.

Simultaneously the story comes from within nurses. This internal story can be made up of the frustration of uncertainty when nurses want to be sure of unresponsive patients' pain, the fear of doing harm and the feeling of inadequacy when others seem sure. Conversely, those nurses who are content working within uncertainty may not feel such emotions. Those nurses who make an effort to become sure experience bewilderment at the lack of information coupled with the expectation to operate under such uncertain conditions. Nurses may also feel frustrated when they are sure patients are in pain but are unable to provide relief. Hearing ex-patients talk about what their stay in ICU was like may result in fear that we have let them suffer unnecessarily. Attending to patients under scrutiny from the relatives may result in nurses experiencing the transparency of inadequacy. Nurses live on hope and calculations.

The collective story describes our encounter with patients, their families and doctors when dealing with the possible pain experience of unresponsive patients. The story ends with our uncertainty. Section 7.3 covers a synthesis from nurses' words, the literature and my understanding of ontology, the nature of 'being', or what I have termed the 'heart' in terms of how nurses deal with uncertainty. Nurses may experience negative emotions in response to the uncertainty around pain care of unresponsive patients. In order to continue to function in their role in ICU, nurses choose ways to cope with uncertainty. 'Being' also involves the relationships between the key players;

nurses, doctors, patients and their relatives. I want to assist nurses to be aware of the elements making up the complexity surrounding their care of pain in unresponsive ICU patients so that nurses can be comfortable working within uncertainty.

The nature of our beliefs about role expectations inherent in our story characters raises status and power issues, as well as highlighting differing goals we value, which impact the way we interact. The complexity of each individual doctor, nurse, patient or family member may influence decisions around pain even if they are not physically present.

1. Patients view on pain – unknown
2. Nurses’ view on pain – to be treated, avoided, dealt with in context
3. Doctor’s view on pain – it may be a necessity whilst recovering
4. Family view on pain – main focus, and must be eliminated

The variation in our life-worlds individually and over time means that, even though we all do the same job, we will go about the doing of it differently leaving the outcomes to also vary. We all bring the self that is available to us now in terms of energy, emotion, cognition, skill, and coping strategies. The nature of the self we present is variable between people and over time. Each group also has at its disposal external things that help with ease of functioning. Nurses want to get their work done, in the form of tasks. Nurses may want other nurses to judge them kindly as ‘good’ nurses; able to make the patient comfortable, finish their tasks and have a tidy bed area. When the patient’s experience is unknown and possibly painful, nurses have a goal to wipe out any patient memory of the experience.

In this section I will cover the concepts of ‘entering the room’ and ‘dispensing satchels contents’ from the dark room metaphor. So that the thought content can be easily read without distraction from the oral form of expression, quotes from the transcripts have been ‘cleaned’ [notations reflecting speech removed].

7.3.1 About expecting to feel certain

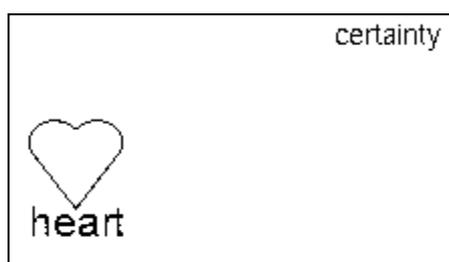


Figure 7.3.2 Certainty in ‘being’

When nurses expect to be certain, and we work within an uncertain situation, the mismatch between our expectation and reality causes emotional responses. Nurses find the uncertainty of unresponsive patients' pain difficult. We are frustrated when we perceive doctors to be limiting the pain treatment options, stressed when we feel watched in our work, inadequate when relatives ask direct questions about pain and anguished in the face of horror and the potential for overwhelmingly painful experiences for the patient. Nurses coped with these emotions by thinking that we were doing a good job or the best we could.

7.3.1.1 Difficulty

If there is uncertainty because of a lack of information and unknown possible outcomes, then the person making the decision will experience feelings of hesitancy and stress in direct proportion to the importance of the decision (Evans, 1990). Relying on technology to measure accurately in order to be sure of what is happening within patients creates a tension when no such technology is available for measuring pain. Relying on nursing inferences based on subjective observations or putting effort into looking for objective pain cues results in uncertainty. The difficulty in making decisions within uncertainty causes stress that can lead to decreased performance and job dissatisfaction (Bucknall & Thomas, 1997).

Leticia says assessment is difficult to do because you're using your ideas and the way you think that person feels and putting them onto them and behaving accordingly (1:1,30-33)

Toni But really sometimes you can't also see that much either. Like if you've got them sort of heavily sedated with lots of morph and things, I mean, you're not sure whether they're just getting breakthrough pain at times, just sort of intermittent or, whether their morph needs to be turned up, or if their PCA's [patient controlled analgesia] working adequately or not, 'cause especially with epidurals, sometimes they mightn't be working effectively and then that's when they should be increased or something. (6:2,1-8)

Robyne was unsure where to aim her care because she was unsure where the patient was at you don't want to over-sedate them, you don't want them to be there in pain, so its a bit hard to know when exactly what's too much, what's too less when you not getting any feedback. (3:1,31-35)

The effect of the pain care we gave was unknown.

Toni reflected the uncertainty I think at times you do tend to think, "Well, you know obviously they're in pain so I'll give them this." Whereas you don't really know, and its hard for you to know, its really sort of catch 22, if you don't give them something, they probably in pain, but if you do, whether they need it or not is another thing. (6:13,29-34)

I thought I'm still not confident of my comfort/pain management skills, because there is no indication from the patient that I have done a good job in this area. I do my best and hope that is good enough for the patient. (Nbview.doc:3,7-10)

Rhea did all I know what to do, and I can't say its a hundred percent right (8:6,24-25) its a very difficult thing to actually do. Who knows what's right and who knows what's wrong. (8:30,21-23) I hope we're doing our best (8:30,27)

The theory of trade-offs and sacred values may explain the difficulty nurses encounter when making decisions about unresponsive patients' pain. Sacred values are absolutes, for example, our mandate to relieve suffering and the goal of saving life tend to be opposed in ICU and having to make a trade-off elicits strong negative emotions (Hanselmann & Tanner, 2008).

7.3.1.2 Stress of being watched

Nurses who expect to be certain may keep busy fulfilling the tasks necessary to observe and treat physical dysfunction because they are able to feel certain about the results of their care. This may result in tension with families who may want nurses to focus on the comfort of patients or who need help with being in crisis. Feeling under scrutiny is anxiety producing, especially if nurses are new or not confident (Hay & Oken, 1972).

Taylor felt anxious when relatives asked her for information she didn't know. You just feel like you're getting watched all the time, getting assessed by the relatives. (9:6,35-37)

I was up working on Neuro and we had a lady that they knew was dying, she was not NFR [not for resuscitation], I actually thought she'd go on my shift and it was a big Greek family, they were all in there with her and howling, which is fine, its their way of dealing with it, but I remember, I was in there and the daughters were asking, "What's she doing now?" and I don't know if you've ever seen a patient jump but they're still going, like their not dead, 'cause I'd never seen it, it was my first dealing with that experience, I had to go up and feel the pulse to see if she was still there, and the daughters going, "Oh, is she still alive? and I'm going, "Yeah." But I found that really hard 'cause the whole time they were going, "What's happening now?" and "When's she going to die?" "When?" you know, and she had a butterfly in her arm, so I was just giving her, she had PRN [whenever necessary] boluses, there wasn't any time limit, and 'cause I hadn't worked with her, I didn't know how frequent I could give it and I remember just going up to the doctor and, I knew, I mean, they knew she was going to die soon and could see that she was in pain and I just didn't know if that little bit I gave her would pull her, or push her over the edge. I found it really hard and then the family being there and, you know, "What are you doing now?" and practically I was giving her last bolus. I wasn't killing her but I was making her comfortable. (9:12,36-13,32)

7.3.1.3 Conflict of weighing up

Nurses who expect to be certain feel the tension of limiting analgesia for body system functioning and may feel relieved when limits are lifted in terminal patients. Once again

the tension between sacred values is relieved when patients are allowed to die (Hanselmann & Tanner, 2008).

Toni I think because we mainly have people in the critical phase, its different pain management than people with sort of like a terminal illness when you tend to be a bit more liberal with the medications and things. And you tend not to have so many hesitations to increasing things and giving more and more, just so that they are comfortable. ‘Cause especially, I think, with oncology patients, there’s no need to be in pain, you know, I’d be quite prepared to give large doses, because they shouldn’t have to be in pain, you know. *(So what sort of things make you hesitate for these type of patients in our unit?)* When they’re trying to either wean them or if they’re just trying to assess their neuro status, you don’t want to give them too much pain relief in case it bombs them out too much and you’re not sure whether they’re responsive or they’re just too bombed out or there’s something neuro, something else’s going on. I think that’s when you get a bit hesitant and try to refrain from giving lots of boluses and things. *(So its like a weigh up thing.)* Yeah, what’s more important really, isn’t it? Especially with your neuro surgery, or big head traumas when they’ve other fractures and things, I think at times you sort of tend to focus more on the neuro part and try not to give them lots of pain relief and things because you want to see whether they’re alert and orientated, whereas, they’ve got multiples fractures, obviously they’ll be in pain. You know, its sort of a ca’ *(Catch 22)* yeah (6:2,37-3,16)

I thought when... *the plan was to wake the patient - then I have to walk the fine line of less comfort and more consciousness (Nbview.doc:1,33-34) its a weigh up thing. If you make them painfree then they’re not going to be as well physically. (5:10,28-30)*

Toni I remember, just recently we had that Mr, that gentleman in [bed number] who was in the halo traction and I think he would have been in a lot of pain, ‘cause he had lots of fractures, but first of all they took the midazolam out of his infusion, then they used to put it back in and then they tried to have his morphine on a really low rate, but, I mean, he would have obviously been in pain that gentleman, you know, and turning him and things, especially, they’d all sort of say, “Only give him boluses if desperately required.” and those sorts of things. *(Why did they say that? Why did they want to give the least amount?)* Because they wanted to see if he was alert and orientated, ‘cause they were worried *(to assess his head)* yeah. But you can see their reasoning behind it but then you can also say, “Well, if he’s in pain, you know, he shouldn’t have to be lying there in pain when you’re turning him and those sorts of things, just to make sure that his neuro status is OK.” But you just don’t know. Well, its hard I suppose, what’s the priority really? (6:p3,16-34)

Hov et al (2007) found uncertainty to be a constant shadow for nurses in ICU in regards to end of life decisions. Nurses did not know the direction of care because goals were not clearly communicated. Nurses also felt the ethical dilemmas between saving life and allowing a natural death; between doing good and doing harm. Nurses in Hov et al’s study were found to live ‘in between’ the hospital and the doctors, life and death and these tensions played out in where they felt responsible.

7.3.1.4 Frustrating

Expecting to be certain of the direction of patient care may end in frustration for nurses when nurses and doctors have different priorities for patients and focus their efforts in

different directions. Doctors typically make decisions that give direction to patients’ recovery trajectories. Holding power may result in doctors behaving in an authoritarian manner towards nurses. Being subordinate to doctors and following orders may suit some nurses in that they can cope with the pressure by not having to think, whereas other nurses feel their input is valuable because they are at the front line and have access to the data, use their heads to make decisions and the doctors rely on them. The most frustrated nurses are those who feel confined by orders and not listened to by doctors after presenting their evidence. It is these who may become subversive, however, it is damaging to relationships to be subversive. The pull for us is to see our profession as right, good and valuable and the other profession as wrong, flawed, and inadequate whereas working together in a supportive way puts people into community. There are also varying tensions with time available, usually doctors having more time than nurses resulting in nurses feeling frustrated that they are interrupted by doctors or they waste time asking doctors for analgesia orders (Bucknall & Thomas, 1997). [Collaboration between doctors and nurses was discussed in section 7.2.4.3]

7.3.1.5 Anguish at patients in pain

Doctors control the resource of analgesia even though nurses usually choose when and how much to give within limits. Nurses can feel hampered in their attempts to give pain relief when doctors impose narrower limits than nurses assess necessary or when analgesia is withheld altogether and nurses care for a patient they believe to be in pain.

Leticia thought it’s a human instinct to a certain extent, you see someone in pain and you want to stop it. (1:12,33-34)

If nurses are unable to provide comfort or alleviate pain, the response was frustration and anguish (Benner, Tanner, & Chelsa, 1996). In this sense it is moral anguish at not being able to address pain through sources outside of our control (Butts & Rich, 2005).

Coping with inflicting pain for neurological assessment involves a rationalisation that the benefits outweigh the possible harm to patients.

I wonder how we cope with all this torture that we do, but that’s another study. It’s all for a reason, that’s why.

Yeah. I think sort of you justify it through that. Yeah, the reason’s pretty important. (5:25,28-26,3)

7.3.1.6 Inadequate

Expecting certainty and thinking others are certain leads nurses to feelings of inadequacy. Not having enough resources creates a tension between what we are capable of doing, what we are motivated to do and what is required of us. Feeling that

providing comfort is a requirement of nursing yet not having enough time or energy to do all the 'little things' leaves us feeling inadequate. Feeling inadequate is a stressor that can cause nurses to become inefficient (Woodrow & Roe, 2000).

Leticia when I don't have an answer to her problem, how do I reconcile that to myself? Well I've done all I can do, now I've just got to turn her, and look the other way, or hope its not too painful or try and reassure her or something, and reassurance, its like suctioning doesn't do anything really, it doesn't stop the pain, doesn't fix it, so if you're really concerned, if you have empathy for your patient then that's the sort of thing that you feel, I think. (1:13,5-13)

7.3.1.7 Coping

The meaning of an encounter between an individual and their environment is made up of how it will affect the person's well being, that is, if it is thought to be irrelevant, benign-positive or stressful and what the person believes about coping resources and options (Folkman, 1984). Stress has been thought to be one of the starting points in the development of psychological and physical problems (Monroe, 2008). It has been shown that stress causes catecholamine release that affects the central and sympathetic nervous system causing changes in affect, motivation and cognition (Greenberg, Carr, & Summers, 2002).

The stress felt by nurses when their expectation to be certain is not fulfilled is different to the kind of stress that evokes a response, rather nurses' feelings around stress result from potential threat or challenge. The stressful event is '**not knowing**'. Some nurses might think 'not knowing' to be irrelevant or benign/positive, but based on my interview transcripts, I would conclude 'not knowing' is mostly stressful. The potential ethical threat is the possibility of 'doing the wrong thing' for the patient who then experiences harm. The potential professional threat is not doing the job properly and thus the sense of self is harmed, being somehow devalued by not performing properly. Facing a potential threat may result in negative emotions of anger, fear or resentment. Challenge provides an opportunity for growth mastery or gain and so nurses may try to get more knowledge [that has been my strategy in doing this study] resulting in positive emotions of excitement or eagerness (Folkman, 1984). Brashers (2001) puts forward the idea that we assume uncertainty needs to be managed by 'coping' measures, but this may not be the case for some individuals.

The appraisal of something as stressful is shaped by belief and commitment. From the cognitive psychology school of thought, emotion results from what we think in relation to stress or negative outcome and if we think the situation is 'controllable' (Lazarus, 1991; Lazarus & Folkman, 1984). Believing that you are in control of a situation does

not necessarily mean that it will be less stressful or conversely, believing that you have no control over something does not necessarily mean that it will be more stressful, rather beliefs determine the resulting emotions and actions taken to relieve the stress.

A personality style of 'hardiness' has been identified as protecting ICU nurses from burnout. 'Hardiness' involves committing to being active rather than passive in life, exerting control through influencing rather than feeling weak and helpless and believing change is normal and provides a challenge that when faced leads to maturity (Maddi, 2002). The traits of 'hardiness' include, "...initiative, willingness to take risks, ability to face uncertainty, and assertiveness in attaining and manipulating external rewards" (Irwin & Rippe, 2008, p2331). It is the capacity for working within uncertainty but still exercising control that would be beneficial for nursing unresponsive patients' pain.

Locus of control (Rotter, 1966) refers to a belief that either internal or external factors cause events or destiny in an individual's life. "A locus of control orientation is a belief about whether the outcomes of our actions are contingent on what we do (internal control orientation) or on events outside our personal control (external control orientation)" (Zimbardo, 1985, p275). An internal locus of control is thought to be healthy and is usually associated with higher achievers. An external locus of control means an individual is guided by fate, luck or powerful others. Participants in my study seemed to display elements from both internal and external control. The physical environment of ICU is very controlled but that does not necessarily mean that the nurses who work there always feel in control from within themselves, at times they might feel at ease being controlled by the doctors, the routines or the nursing hierarchy. Some nurses with an internal locus of control take steps to persuade doctors of their assessment of patients' pain or the need for analgesia while others with an external locus of control sit back and acquiesce.

A sense of control can come from cognitive coping strategies where an understanding is rearranged so that there is no longer a potential threat and thus is less anxiety producing (Reutter & Northcott, 1994). For example, nurses can believe patients are not experiencing pain if they rearrange their understanding of grimacing to be caused by uraemia or the patient with liver failure having encephalopathy. Focussing on the things needed to be done for the patient to survive can be a distancing from the topic of pain. Covering with morphine infusion can be a 'safe' practice because nurses consider pain has been dealt with and that means continual pain assessment may not be required. Believing recovery is more important would make dealing with pain less of an

issue. Believing dying is painful would result in more stress if analgesia is not given liberally.

To some extent ICU nurses' view of reality may be distorted by what becomes routine to us. Defining 'reality' is dependent on an individual's perspective. It is possible we distort reality to survive through the use of 'adaptive patterns' which the broader system enforces (Kavanagh, 1988). Some coping mechanisms help to sustain response shift to remain intact or even positive psychologically as in the case of partners of people dying from AIDS (Richards & Folkman, 2000). "Adaptation is a process of change whereby the individual retains his integrity within the realities of his internal and external environment" (Levine, 1973, p11). Conservation of self is the outcome.

Some people try to resolve uncertainty while others avoid it (Sorrentino & Roney, 2000). For some nurses in this study, resolving uncertainty involved taking steps to become more certain through acquiring knowledge while those nurses who avoided uncertainty focussed on other measurable priorities or took a stance of being certain about unresponsive patients' pain.

Commitment shows what individuals hold important and the extent of commitment is related to beliefs about control. Commitment to recovery, comfort, appearances as a 'good nurse' or maintaining favour with the team leader or doctor will motivate nurses' actions. "Theoretically, the more serious or extensive the commitments involved in an encounter are, or the more at stake these commitments are for the person, the more important it may be for the person to believe that he or she can control the outcome of the encounter" (Folkman, 1984, p842).

If a person thinks that the stressful situation involves harm or loss, is a threat or is challenging, then they will think about what they can do about it in terms of coping resources and options. Coping resources include physical [health energy stamina], social [social network and support which can help with information, helping hand, emotional support], psychological [beliefs sustain hope, problem solving skills, self esteem, morale], and material [money, tools, equipment] (Folkman, 1984). Participants talked about the lack of physical resources on night duty in terms of tiredness and wanting to sit down, about asking others about their opinion on what was happening for patients, about being too busy, about not having enough help to do pain care properly and about the unavailability of equipment for measuring pain. Beliefs about midazolam erasing memory of ICU experience gave hope that the awfulness was only temporary.

In real life situations some things may be thought to be able to be controlled whereas others are not. Nurses do not control legal ordering of analgesia but do exert influence over obtaining an order by which doctor they approach and how they ask. Nurses control the rate or frequency of analgesia within doctors written or verbal orders. Nurses control the nursing actions done to patients to some extent in terms of how gently or thoroughly they are done, but do not control frequency of interruptions or the pain of some procedures they must do like dressings or neurological observations.

Coping involves two aspects which deal with the emotion associated with the stress and the problem itself. Emotional focussed coping tries to control distressing emotions sometimes changing the meaning of the event to do so. Problem focussed coping tries to fix things by problem solving, decision making, and actions which can be directed at self or at the environment (Folkman, 1984). I have been involved in problem focussed coping by doing this thesis. Participants also undertook problem focussed coping to some extent by looking for answers from their colleagues or doctors. To rethink the situation so that it is not possible for people who do not respond to experience anything, or that for certain medical conditions pain cannot be felt like uraemia, is to deal with the distressing emotion without solving the problem.

Exercising control over one part of a situation can cost in other areas (Folkman, 1984). In the case of obtaining analgesia orders, nurses going behind doctors' backs to get an order higher up can put in jeopardy the relationships in the natural line of command that have been usurped. Telling the wardspeople and x-ray technician to wait while you suction may cost nurses good relationships with those we rely on for a helping hand.

Negative emotions associated with stress need to be kept in check in order for problem focussed coping to occur whereas positive emotions associated with stress enhance thinking (Folkman, 1984). One example comes to mind of a newer nurse feeling anxious and uncomfortable with 'not knowing' because the relatives were asking about the patient's pain so the nurse went and asked the doctor. Some nurses may cope by reappraising the situation as outside our control.

Matching the appraisal of control with the controllability of the situation is related to how adaptive or maladaptive the outcomes are. If a person thinks a situation is uncontrollable when it can be controlled, then there is a possibility of harm and low morale whereas if a situation is uncontrollable but the person tries to control it, after a

lot of problem solving they will get nowhere and become frustrated and disappointed. So coping effectively involves knowing when to give up trying to change the situation and turn instead to tolerating or accepting it by emotion focussed coping (Folkman, 1984). The belief that unresponsive patients cannot experience pain would result in actions directed at their physical well-being not all other aspects, and so the possibility for harm is to patients. The belief that patients' pain experiences can be known would result in a lot of time and energy spent trying to find out. If patients' pain cannot be known and nurses reappraise to think they do know when they cannot, it seems an arrogant stance but it is also a coping strategy. Nurses may just feel disappointed like me. So the adaptive outcome would be to accept that no one can know about unresponsive patients' pain and work within that by 'doing our best'. The best will depend on the resources nurses come with and therefore each nurse's best will not coincide and there will inevitably be discussion. If people understand why there are differences, then a more positive outcome of discussion should result.

It is the complexity and the uncertainty that we need to cope with. Narrative explanation talks about what we do to cope. We face nursing patients who may be experiencing something between awfulness to possible torture. We may put the responsibility onto science to find a way of measuring pain, or we may expect us as nurses to increase our knowledge or experience or status or speaking up, we may ask doctors to listen more or have different priorities, or we may resign ourselves to the ICU setting being a place of other priorities and distractions. In order to feel good about ourselves and ameliorate the position we are in, we have to believe our practice is the best we can do. In this way we cope, otherwise we may psychologically dissolve. One way of coping is to be certain anyway through intuition or gut feelings. The strength, by which we appear to be certain in the face of uncertainty, is equal to the possible horror if we are wrong. An alternative coping method is handing over assessment to the doctors because we believe they know more or they will be responsible instead of us. We may cope by concentrating on other priorities or fitting in with the routines of ICU and changing allocations which promote distancing and focus on body parts rather than the whole person. Each of these ways of coping impacts negatively on nurses and patients. Coping by understanding the complexity we work within, valuing our contribution, and realising we are not alone in this difficult experience will help us meet our needs of significance and connection and will assist us to be more considered in our assessment consequently impacting positively on patient care.

7.3.2 About the certainty of significance [not entering the room]

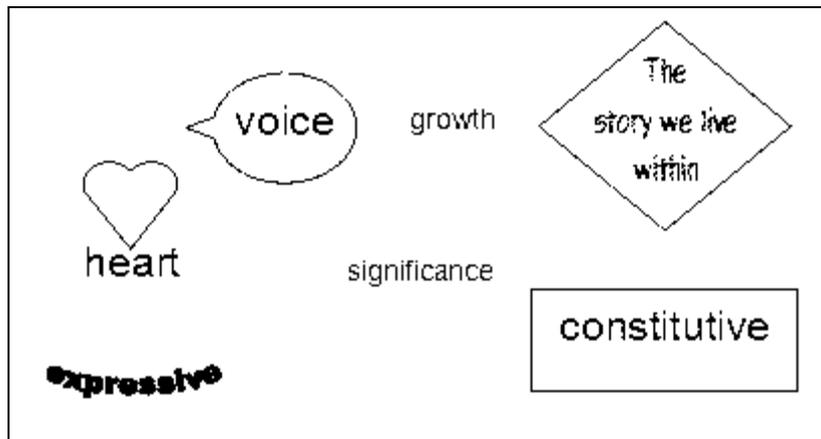


Figure 7.3.3 Growing more significant in 'being'

We are surrounded by metanarratives concerning our place within the multidisciplinary team and expected ways of relating with other members as well as expectations from the profession of nursing. As a way to move to a place of more certainty, nurses with an external locus of control may choose as their 'powerful others': doctors and/or the mandate of the 'comfort role' in nursing. These two options of becoming more certain can meet the need of nurses to feel significant in their role. When nurses just follow doctors' orders, shift their perspective towards a medical model or put in effort to be seen to fulfil the nursing role of comfort, there is an external evaluation of significance by the 'powerful other' they are serving.

7.3.2.1 Significance from doctors

A way of avoiding uncertainty is for nurses to focus on rescue and look away from what patients experience in order to cope. When nurses believe that pain is not as important as recovery they give their attention to saving lives. Giving importance to technology and tasks by attending to the machines instead of the patients may indicate a shift in nurses towards a medical model. Technology can take up nurses' attention, thus impeding connection with the patient (Barnard, 2002). Seeking certainty through a focus on rescue may relate to skill acquisition as Walters (1992) found more experienced nurses to be 'in tune' with the human-to-human dimension of nursing rather than being taken up with technology.

There is usually immediate measurable feedback for actions directed at the goal of recovery but with unresponsive patients there are no obvious immediate consequences resulting from allowing unnecessary pain. Unresponsive patients cannot cause an auditory disturbance, pester nurses for analgesia or give negative reports to their

family; instead they just silently lie there. The judgment that nurses have done a good job will come from others.

When nurses take the option of not focussing on pain cues it can result in internal dissonance with the comforting role of nursing. Conversely, searching intently for pain cues puts nurses out of step with the need to rescue in ICU. Coping by focussing on physical recovery helps ease the tension of seeing ourselves as comforters and carers when, at times, patients' pain seems obvious and is unable to be relieved.

Patrick I guess you're biggest concern in intensive care when they're really critically ill is their medical side of things, and I think to me that sort of needs to take precedent because they go off so quickly. I mean, "Do you want to have pain or do you want to be dead?" So its easier I think for some to justify that someone is in a little bit of pain, as long as that's not for a prolonged period of time, that is for normally turning or and as soon as we've turned him they can settle down I think. You sort of justify the fact that they're in a bit of pain. (5:10,7-26)

Minimising the impact of the routine procedures and technical interventions that we frequently impose on patients protects us from seeing the human response.

Conversely, personal experience helps to bring home the possible experience of patients while undergoing such procedures.

For example, Toni's experience of an arterial stab, one of my friends did a blood gas on me last year, 'cause I wanted to see what it felt like, 'cause I always used to say, "I'm just going to do a little prick, it'll hurt a little bit." 'Cause we used to do them all the time. Bored, and I thought, "Oh." I just wanted to check my haemoglobin just on a gas. Oh, it was just excruciating, OK, it was terrible, it really, really hurt. I had pain radiating all the way up my arm, 'cause, you know, how you always say, "Oh, it'll hurt a little bit." Oh it was absolutely dreadful, it was worse than having a blood test or a cannula put in, really hurt and then it throbbed afterwards. And it wasn't as if she did a bodgie job, ' cause she got it straight away, and after that I've always been, "This will hurt". (6:24,10-28)

Working closely with doctors, and maybe believing doctors 'know' more, provides the opportunity to bow to their opinion by asking what is their assessment of the pain in unresponsive patients so that we do not need to consider the uncertainty.

Relinquishing responsibility or being subversive is potentially damaging to nurses and the community because the good that would be done by adding the nursing point of view is lost or the subversive actions destroy trust and respect between the multidisciplinary members. Nurses must accept responsibility and accountability for their practice. Mauksch and Campbell (1987) and Weiss and Remen (1983) found an unwillingness to be responsible and accountable hindered nurses collaboration and professionalisation. Primary nursing is a way of one nurse being responsible and accountable for a patient's care and in turn enhances communication with the doctors

(King, Lee, & Henneman, 1993). [‘Knowing the patient’ was discussed in section 7.2.3.7 and nursing continuity of care was discussed in section 7.2.3.9.] Both groups need insight into the other’s perspective on care for there to be open communication (Crisp, 1987), which will in turn result in understanding and respect within the nurse/doctor relationship (S. K. White, 1989).

7.3.2.2 Significance from comfort as a nursing mandate

Comfort is a mandate of nursing. The Australian Nursing and Midwifery Council’s third explanatory statement in relation to Value Statement 1 “Nurses respect individual’s needs, values, culture and vulnerability in the provision of nursing care” includes comfort, “Respect for individual needs, beliefs and values includes culturally informed and appropriate care, and the provision of as much comfort, dignity, privacy and alleviation of pain and anxiety as possible” (Council, 2002, p3). Nursing theorists also endorse comfort as a critical indicator of the success of nursing actions (Orlando, 1961; Paterson & Zderad, 1988).

Because comfort is a human need nursing actions should be directed at unmet comfort needs of patients to provide enhanced comfort (Katharine Y. Kolcaba, 2003, 2006). Add to this claims such as Morse (1983, p6), “Comfort is the most important nursing action in the provision of care for the sick. Whereas *caring* provides motivation for the nurse to *nurse* and to provide maintenance, restorative, and preventative actions to promote health, *comforting* is the major instrument for care in the clinical setting.” [original emphasis] Nurses are expected to provide nursing actions that promote comfort in patients (Campbell, 1984; Goodnow, 1935; Nightingale, 1859), however, comforting unresponsive ICU patients was not so simple. Wilkin and Slevin (2004) found ICU nurses associated comfort with physical care and ensuring these vulnerable patients were pain-free.

Comfort as a noun is derived from the Latin *fortis* meaning strong, leading to the idea of strength and health (J. M. Morse, Bottorff, & Hutchinson, 1995). Morse (1992) suggests “...the ultimate purpose of nursing is to *promote* comfort for the client rather than to *care for* the patient” (p92) [her emphasis]. She defines comfort as the outcome of nursing actions either temporary, as in the relief of pain, or long-term, as in health. However, comfort usually is understood in relation to its antithesis; discomfort or pain (Katherine Y. Kolcaba, 1992; J. M. Morse et al., 1995). Kolcaba (1991) suggests that comfort occurs when the patient’s needs of ease, relief and transcendence are met.

Asha I think we forget we're nurses, and nursing's a skill on its own and I can't define it, I don't know how to define it; its about people, its not for us to diagnose or to treat, you know, prescribe drugs or treat disease processes, that's what doctors are for. We're there for patients' comfort, and a lot of things, you know, to coordinate all the multidisciplinary teams that we have, but, most of all we're there for patients' comforts and I think that's our skill, looking at the patients, trying to get them comfortable, and safe, I mean patient safety has to come first as I said, but there's other things too. The patient first and foremost. (2:4,19-30)

7.3.2.3 Comfort as the measure of a 'good' nurse

Comforting has traditionally been associated with nursing (Donahue, 1989; Katharine Y. Kolcaba, 1992), in fact, nurses are often judged by their ability to make their patients comfortable (Katherine Y. Kolcaba, 1992; J. M. Morse et al., 1995). The families of ICU patients look to nurses to keep patients comfortable (Heland, 2006).

Patrick talked about comfort being a measure of a good nurse. I think its a very big issue in your training and I think that its very hard for nurses to measure how effective they are and one of the very few things that we can sort of have a direct measure of what sort of job we're doing is whether someone is in pain or out of pain, pain-free, and I think that's why we tend to make sure of that, you know... because any other things you've just got so little control over like with blood pressure and stuff, there's no measure of whether you're doing a good job or not or whether the wound's healing or not, because you can do things but you can never actually say, "Well, because I put you on the zinc, that's why your wound healed. So that's one of the very few things where you get a direct measure of how well you're performing. (5:23,24-30 and 24,14-22)

Using the nursing mandate, to 'provide comfort' as a measure of quality nursing, was an additional aspect of the complexity of this nursing situation when some nurses looked away from the possibility of pain and looked towards their performance as a nurse. At times, pain is not as important as being recognised as a 'good nurse' by others. Measuring the standard of nursing care by how comfortable patients look does not necessarily result in patients being comfortable, for example, a neat and tidy paralysed patient may not move but may be in extreme pain. Uncomfortable looking patients are restless and messy and the attending nurse feels that their job is never 'done'. Good nurses are also up to date with their work so task completion is also a measuring standard. Walters (1994) found providing comfort was a priority among the expert ICU nurses he studied. This was carried out through talk, touch and making the patient look good.

Beliefs about measurement of a 'good' nurse as one who can make patients look comfortable motivates us to make patients comfortable before their relatives see them so that relatives can be the 'powerful others' to bestow a judgment. The use of sedation can also be linked to making patients look comfortable which gives nurses a break leading to the assumption of patients' safety so nurses have less stress, can look

outside their own bedspace and watch other patients because we are a team and there are different levels of competence.

7.3.2.4 The caring mandate as the basis of connection

Fulfilling the nursing mandates of ‘caring’ and ‘justice’ as metanarratives of the profession, may not hold significance for nurses but is closely linked with connection with patients. Nurses can absorb the expectation of providing care in a just manner through listening to the tenets of the profession and so these concepts are ‘constitutive’.

“Care, the central focus of nursing, is a process occurring between the patient and nurse focused on the attainment and maintenance of health or on a peaceful death. Personal qualities of the nurse, including genuine concern for the well-being of the patient, must be combined with actions taken in the interest of the patient for the experience of care to occur” (Brown, 1986, p58). Because the term caring has been under accusation of being ambivalent and not comprehensive enough to cover all that nurses do, several writers have suggested ‘commitment’, ‘connecting’ and ‘comfort’ as being more appropriate (Clayton, Murray, Horner, & Greene, 1991; J. M. Morse, 1992; van Hooft, 1987). Walters (1992) defines care as “...persons, events and things matter to people” (p59). Gaut (1986) purports action is critical to caring; it is not just an attitude. Brown (1986) link actions taken to manage pain and both Larson (1987) and Leininger (1986) associate comforting touch with caring in nursing.

“A patient can have a very skilled, knowledgeable physician, but if the nurse is lacking in diagnostic, monitoring, or therapeutic skills - and, most serious of all, if the nurse does not care - the patient’s chances for recovery, or for dignity and comfort in dying, are slim.” (Benner, 1984, p216) (pap302)

Although it is claimed that caring is central to nursing, there are many different and confusing aspects of the concept (Burns & Grove, 2004). Caring has been related to nurses’ view of wholeness (Arndt, 1992; Boykin & Schoenhofer, 1991) and is said to be manifest in ordinariness (Taylor, 1993). However, it has also been divided into the fondness for and the fulfilling of needs in another (Griffin, 1983). If the needs are fulfilled in a caring way, it conveys that the patient has worth as a person (Brown, 1986). Mayeroff (1971) goes further to require an understanding of the patient’s world, as though the nurse were in it, in order for the nurse to care. If the nurse does not ‘know’ the patient, the nurse takes care of them rather than caring for them. Van Hooft (1987) claims this type of caring is not possible for the unresponsive patient.

Morse et al (1990) structured a summary of the nursing literature on caring and organised it in terms of five categories:

1. a human trait
2. a moral imperative
3. an affect
4. an interpersonal relationship
5. a therapeutic intervention.

Caring as a human trait is thought to be influenced by the experience of receiving care and is culturally specific. This would result in differences in caring among nurses.

As a moral imperative, caring is shown through commitment to maintaining integrity and dignity of the patient and should be the basis for all nursing actions (J. M. Morse et al., 1990). Reverby (1987) makes the point that nurses need autonomy in order to care; without autonomy nurses cease to care or cease to nurse.

Caring as an affect is seen in emotional involvement with or an empathetic feeling for what the patient is experiencing (J. M. Morse et al., 1990). Leininger, (1986) sees empathy as one of the constructs of care. Empathy has been described as a process of, without judgment or evaluation, placing oneself in the experience of another while retaining one's own separateness (Pike, 1990). Ethically orientated writers have asked how can one invade the private sphere of another's mind? They warn of dangers of projection and self-fulfilling prophecy. Proposing instead for nurses to have an appraising sympathetic perspective rather than immersion in another's feelings (Griffin, 1983; J. M. Morse, Anderson et al., 1992). Walters (1992) suggests that empathetic nurses, who are usually more experienced, are more creative in their approach to individual patients.

Within the interpersonal relationship between nurse and patient, caring is thought to be seen in interactions, encompassing both feelings and behaviours (J. M. Morse et al., 1990). "Caring involvement and interaction incorporates, on the part of the nurse, a preference for 'being with' rather than 'doing to' a patient" (Forrest, 1989, p818). The depth of caring described by some nursing writers as being a part of nursing would not be possible to sustain, either psychologically or because of time. A profession should have limited and attainable goals (van Hooft, 1987). Webb and Hope (1995) suggest that physical caring, as exhibited in basic and technical nursing skills should not be separated from emotional caring, rather, both should compromise the caring of nursing.

Sometimes, nursing involves actions that do not generate warm feelings. In these situations, nurses care by attending to the longer-term outcome (Watts, 1993).

Caring as a therapeutic intervention involves specific nursing actions and how these actions are carried out (J. M. Morse et al., 1990). Practical caring can only occur when the nurse 'knows' the person of the patient and 'knows' what can be done to improve the situation (Jenny & Logan, 1992). "In the best nursing practice, science and technology are the tools for caring" (Benner & Wrubel, 1989, p372).

For caring to take place, nurses need to be mature in their personal lives, professional and follow principles of commitment and respect (J. Morse, Bottoroff, Anderson, O'Brien, & Solberg, 2006).

7.3.2.5 The justice mandate as the ideal of connection

Although the nursing profession has an ideal of quality nursing practice to all patients equally (Botes, 2000; Catalano, 2008), nurses are more motivated to care for the comfort needs of some patients more than others. This seems to be related to the attraction of the patient from the nurse's point of view and the connection achieved in the nurse-patient relationship. Attraction depends on similarity to nurses' self or family member, whereas, lack of attraction results from patients' threatening behaviour or pathophysiology. Relatives also contribute to the attraction between the nurses and patients by telling the nurses of the patients' personhood or by irritating the nurses, interrupting their work or asking difficult questions. Of course, nurses' interpretation of what these patients are experiencing, via their intuition and what the nurses think would be of benefit, which varies according to the nurses' experiences, also influence the decisions they make regarding how to give comfort care to these patients.

Bryce related an hypothetical case where he highlighted the generally accepted view of equality of care and yet showed that in reality care is given to meet the needs of the individual patient.

Bryce If you went into things like, this person just bashed up someone and then the cop shot him, does he deserve that? I think you'd find people might be saying that, "Yes, he definitely deserves it." But OK, (*but if he came into ICU and you were looking after him*), Yeah he still deserves the same degree of care. People sort of say, "No he should've been left on the street to look after himself and manage his own wounds." But no, everyone deserves a degree of pain relief that is satisfactory to them, not satisfactory for us, satisfactory for us so as not to affect them in any sort of physical way, but yes satisfactory for them. (4:8,21-36)

"A vision of 'treating everyone as the same' is a distorted vision of 'justice', since in situations of different levels of risk and vulnerability, responding to the vulnerability, needs, and possibilities at hand is the relational ethical demand" (Benner et al., 1996). Justice is a rational ethic, developed from the 'Enlightenment' and valued in western society. The relational ethic of caring has been forwarded as an alternative and is more related to ordinariness (Gadow, 1995). Gadow (1995) suggests a tandem approach to both of these ethics, taking a separate but equal approach. However, a more distant stance is promoted to ensure justice (Ashcroft, Dawson, Draper, & McMillian, 2007). In clinical practice, ethical principles and notions of good guide clinical decision making (Benner et al., 1996). The notion of good is embedded in ICU practice (Benner & Wrubel, 1989).

It is socially constructed, both within the profession and the unit, that nurses will do what is 'good' and in the best interest of the patient. The culture of a unit determines what excellent practice is and what is taken-for-granted or ordinary. "Each unit culture sets up patterns of practice, relationships, surveillance, and transmission of clinical and caring knowledge" (Benner et al., 1996, p223). Motivation to do what is 'good' comes from the serious nature of possible consequences of not doing the job well; even the death of the patient. Alleviation of suffering is one of the nursing activities thought to be good; a moral responsibility. It is thought that most nurses would intellectually agree with this but it may not be evident in their practice. If nursing was guided by this ethic, then the possibility of providing comfort or alleviating pain would permeate all nursing activities. In fact, it has been claimed that a patient cannot recover unless they are maintained in a state of comfort. Comfort allows for renewal, including strengthening and a positive outlook (Benner et al., 1996; Katharine Y. Kolcaba & Kolcaba, 1991).

Asha's ideas of what would have been caring actions differed from the wardsmen and less experienced nurse.

Asha Just the other day we were lifting a lady back into bed, an old lady with Guillain Barre, fully aware, and obviously a lady, not that this should matter, but she's been a very grand lady in her day, she was 87, and she's obviously a very modest lady as well, like her daughter brought in her hair colour because she'd just die if she knew that her hair looked like it did, and trying to get someone to wash that lady's hair and put the colour in was impossible. You know, I'd go to do it and they'd just say, "Oh, just leave her, you know, we're going to do physio now, we're going to do something else now." That was very important to her to have that colour in her hair. Sounds silly but there was no need not do that, but anyway, lifting her back in bed, and the poor thing had the wardsmen around the back of her, and sometimes I look at things like this and I know that there's no other way to do it, but I you just feel so helpless and a young nurse at her feet doing a top tail lift back in bed and she's all crunched over, had this man's hands on her breasts, which she must have just been horrified with and they went

to lift her back and anyway he hurt his back and they just dropped her back in the chair and I just cringed when I saw it but then I kicked myself because I should have said, you know, “We need more people for this lift, we haven’t got enough people.” But everybody forgot about her because she couldn’t speak, she had a tracheostomy, you know, I was standing there watching and then I eventually went over and said, “Are you all right, C?”, you know, “I’m sorry this has happened.”, explained what had happened. But yeah, just because people can’t talk. (2:9,17-10,10)

7.3.2.6 Voicing

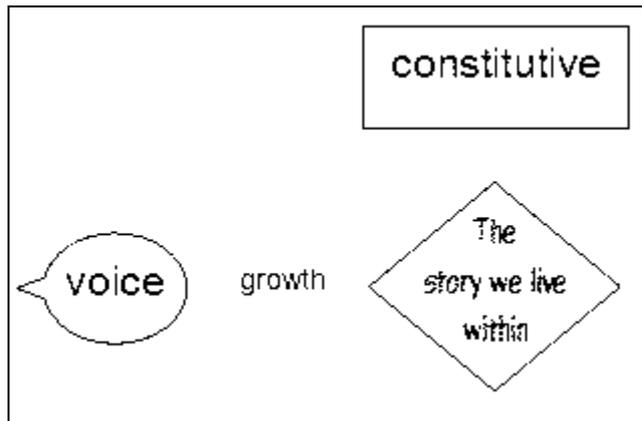


Figure 7.3.4 Growing through listening

From this study, how ICU nurses choose to ‘be’ in relation to their care of unresponsive patients’ pain is influenced by expected roles that they may prefer to fill. Nurses listen to the ‘voice’ of external sources, such as doctors or the nursing profession, to hear how to ‘be’ and then filter and assimilate from the metanarrative what they want to keep. This listening process fulfils the need for nurses to grow. When nurses listen with a critical stance we can find the autonomy we need to decide own role.

Michael Rowe (2003), a sociologist trained in qualitative methods of research, lost a son after a struggle with sepsis following liver transplantation. Rowe used this intensively personal experience as a catalyst to find meaning in the situational structures surrounding the last few days of his son’s life. Focussing on roles and interactions, Rowe showed the impact of the norms of relating within the medical hierarchy [the night resident being unable to secure a timely review of the patient’s deteriorating condition], the impact of the patient’s significant others’ behaviour on the staff making decisions about care [Rowe as father not demanding action to be taken], the possibility of casual comments, either spoken or written, having significance beyond that intended [the comment in the notes that the patients looked well when analgesia masked symptoms of bowel perforation]. Rowe points out how the accepted structures of clinical practice can influence people’s action and also how people’s

actions tend to ensure the structures stay in place [there are always some exceptions that lead to change]. Rowe suggests the ethic of ‘patient first’ can only be a reality if the hierarchies are opened out and questionable decisions challenged by anyone with moral competence. Rowe believes that technical competence is teachable but moral competence is inherent.

7.3.3 About certainty through connection [entering the room]

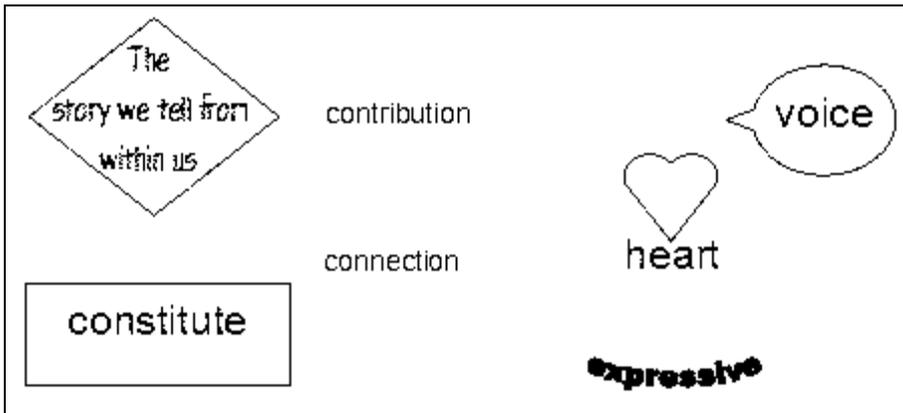


Figure 7.3.5 Contributing our connection in ‘being’

Although we live in a society that values achieving rather than connecting (J. Lawler, 1991; Montgomery, 1992), we found connecting to be a helpful way of getting close to what these patients were experiencing. Connection has been defined as transpersonal experiences and feelings that attach or bond nurse and patient (Clayton et al., 1991). I would define connection as a link which motivates and allows nurses to do all in their power to help the patient. Morse (1991) describes a connected nurse-patient relationship as one where the nurse ‘sees’ the patient first as a person and then as a patient. There is an integration of the patient’s body as an object or thing and the personhood of the patient as subjective (Sakalys, 2006; Allan John Walters, 1992). Within this connected interpersonal relationship between nurse and patient, caring is thought to be seen in interactions, encompassing both feelings and behaviours (J. M. Morse et al., 1990). “Caring involvement and interaction incorporates, on the part of the nurse, a preference for ‘being with’ rather than ‘doing to’ a patient” (Forrest, 1989, p818).

Nurses’ strategies for resolving uncertainty through putting more effort into ‘knowing the patient’ are closely tied with the concept of nurse-patient connection. The strength of conviction nurses show towards what we believe patients are feeling may be in direct proportion to the possible horror if we are wrong. The resolution of uncertainty, or

becoming certain, leads to more difficulties when our conviction does not align with the doctor who holds the powerful anti-pain agents – then we have to make a case, work with our hands tied, do what we can, be gentle and hope it is not too bad. If uncertainty remains, covering with midazolam is like a bandaid ‘just in case’. It eases our minds of the possibility of awful experiences being remembered by patients. Midazolam represents a small measure of control that we can muster to cope.

Putting effort into becoming close to unresponsive patients is valuable as a motivation for caring actions when it allows more pain clues to be detected, but being close can also be detrimental when we lose sight of the bigger picture for the patient and make decisions based on emotion. The value of professional distance in interpersonal relationships has been recommended to keep the carer’s self intact (Basford & Oliver, 2003).

We felt less anxious when we located ourselves somewhere on the continuum of connection to disconnection with patients. [See Figure 7.3.6] Some of us feel more comfortable getting close to unresponsive patients in order to find out as much as possible whereas others of us feel more at ease at a safe distance. Researching the topic in order to reduce my uncertainty shows that I tend to want to get closer and look harder at the ‘silhouette’ to find out more and this puts me at the connection end of the dichotomy. The way that I went about obtaining information for this research from my colleagues ensured that I learned about ‘looking’, however, the counter-story of ‘not looking’ or being disconnected is also described. Originally attributed to Thomas Hobbes (Klein, 1970) the approach-avoidance dichotomy involves movement towards or away from a situation. Tensions can be the prerequisite to the movement, that is, we move to relieve the tensions.



Figure 7.3.6 The nurse/patient relationship continuum

Nurses choose where to locate ourselves on this continuum to provide optimal care. Coming to care for these patients as strangers and having no history together puts us in a position of choosing where we locate the nurse/patient relationship we form for that

shift. Walters (1992) claims that nurses' awareness of their own inner experience helps in person-to-person contact. Therefore, the degree and type of connection felt by nurses is as individual and variable as personalities and situations (Ramos, 1992).

The extreme of connection is over-involvement. This has been defined as unrealistically wanting to rescue a patient or take over the family's control (Benner et al., 1996), where there is no balance between cognition and emotion; too much emotion (Ramos, 1992), seeing the patient as a person only; disregarding input of doctors and institution and neglecting other patients (J. M. Morse, 1991). Unusually close connections between patient and nurse are not possible or sustainable for all patients. Over-involvement is thought to be unhelpful and interferes with good decision making on an individual level as well as equality of care on a unit basis (May, 1991). There have been warnings about locating ourselves towards either extreme, totally disconnected nurses are cold and hard, whereas totally connected nurses enter into the patient's suffering themselves. Therefore, optimal care depends on a balance (Collins, 2007; J. M. Morse, Bottorff, Anderson, O'Brien, & Solberg, 1992).

7.3.3.1 Ways of achieving connection

7.3.3.1 (a) Knowing pathophysiology

A degree of connection was made possible by the nurses knowing the pathophysiological processes occurring within the body of the patient. For example, sympathetic stimulation or the relationship of where tissue damage occurred to what might be felt. Imagination was the link that connected this knowledge to the possible experience of the patient.

7.3.3.1 (b) Nurses linking to similar experiences

Personal or close family experience of surgery, back pain, or minor procedures such as cannulation or arterial puncture allowed the nurses to use the feelings they felt to imagine what these patients felt, although they did acknowledge individual response.

Robyne my father has had chronic back pain for as long as I've known and I'm always aware that he can't stand for too long, he can't sit for too long, he can't be in a car for too long, he has to have his legs straight, you know, there's all these things that he can't do, he can't bend, and although he hasn't taken a hell of a lot of pain control things for his back and he's had a fair few operations, its always sort of made me think, from a young age, about pain, and how much, how distressed he became with it, because as my next of kin really, he was the most honest I think anyone would be with another human being, about the level of pain they're experiencing, and, you know, you know what men are like when they're in pain but and that's another assumption! I suppose I always find myself thinking when someone comes in and they say that they've got a bit of back pain, its like, "Oh my god. Lets get them something." I suppose, helped develop empathy towards people in pain. (3:3,32-4,16)

7.3.3.1 (c) Knowing the person of patients through relatives

The nurses also used contact with these patients’ relatives as a way of connecting with the patient. Looking through the relatives’ eyes at the patient, the nurses were able to know the patient better as a person and focus more on comfort. Watson (1987) found that having a picture of the patient by the bed helped nurses to relate better and communicate with both the patient and relatives. However, caring for the information and support needs of relatives can hinder connection with patients.

Taylor I was in there and the daughters and that were asking, you know, “What’s she doing now?” ...I found that really hard ‘cause the whole time they were going, “What’s happening now?” and “When’s she going to die?” “When?” you know. (9:13,10-18)

7.3.3.1 (d) Contact time

The nurses found that time spent in contact with a particular patient helped them to connect. Compared to other staff, nurses are more constantly in contact with their allocated patient during their shift. Doctors tend to make decisions more based on their own assessment of the patients during the short time they see them on rounds rather than what the nurses might say after being with the patients all shift. Stein-Parbury (1999) found doctor’s not taking notice of nurses’ assessment during eight hours but relying on two to three minutes of questions to evaluate confusion and then thinking that sedation was for the benefit of the nurse.

Toni, they [the doctors] just come along and say, “Well we’d better stop the sedation or stop the analgesia or decrease it or something.” You say, and then if you could, if they would just listen to you a bit more I think, ‘cause you’ve been there all day and you know how your patient is and (*why you’ve got them to that state at that time*) to that point, time, yeah. (*Yeah, what’s happened just before*) Yeah, exactly, so I think as nurses we’re not often, sort of given enough credit for being able to ascertain how uncomfortable your patient is or how they’re too comfortable or whether they’re getting too much pain relief or not enough. (6:6,34-7,8)

7.3.3.1 (e) Trying to ‘see’ or ‘do’ more

Drew (1986) as well as Reiman (1986) found that patients were sensitive to caregivers’ tone of voice, facial expression, eye contact and movement, interpreting these as close [caring] or distant [non-caring] behaviours.

Minimising can also be a sign of connection when it is used to protect the patient from unpleasant aspects of care. Lawler (1991) talks about ‘minifisms’; nurses minimising in order to not alarm the patient. By minimising talk, nurses contain the anxiety of uncertainty within ourselves in order to protect patients.

Patrick minimised what he saw, when he said, its like "Oh, look, I'm just doing your dressing here," and its like and your abdomen is right open, you know (5:7,27-29)

Involvement with patients' relatives allows nurses to draw on additional resources to achieve connection. Relatives can help nurses to 'know' the patient if nurses value the fact that they 'know' the patient best (Benner et al., 1996; Benner & Wrubel, 1989; MacLeod, 1993). In this study, we found patients' relatives both helpful and hindering in our attempts at connecting with these patients. Nurses are sometimes faced with both a critically ill patient and needy relatives for whom to care. They may feel they do not have the time to do both properly. Walters (Allan John Walters, 1992) talks about focusing on the patient and giving the patient identity as well as focusing on the needs of the relatives. Relatives of these patients influenced our consideration of comfort. Relatives of critical care patients are in crisis and need support. They are uncertain too. From the relatives' point of view, aspects of this support include information, assurance of good care for the patient, and comfort for themselves (Chen, 1990; Ladanyi & Elliott, 2007; Leske, 1991; Woolley, 1990).

Relatives helped us to focus on comfort.

I thought when the patient's relatives are going to come in, you also look at the patient in a different light, look at them through what you think the relatives are going to see. (5:20,26-30)

Contact with relatives caused Patrick to reconsider his patient's comfort and pain, he said, when relatives ring to see how the patient's doing, especially with the ones that are like really unconscious I think we'll always make a point of saying, "Well, they're comfortable and they're pain free," and I've guessed that they're pain free. If nothing else, it still makes you think, you know, "Is he really, he or she really pain free or not?" At least it comes back into your brain and makes you look at it again, and see whether they are or not. (5:20,13-17,21-25)

Sometimes relatives asked us directly about comfort.

Taylor's patient, a person who couldn't communicate (9:4,17) it was a head injury, and all his vitals were OK, he was just laying there. He looked comfortable but the relatives kept asking me, "Are you sure they're not in pain?" And they weren't on any infusions or anything and I wasn't certain that they weren't in pain (9:4,24-29).

We made the patients comfortable for the relatives to see.

Patrick felt that maybe we're sort of delaying the time between the patient arriving and the actually letting the relatives in for the relatives' sake, to have the patient nice and comfortable and pain free and clean sheet and I think that's another one of those things where we just take a guess, because I think sometimes that is good for them and other times people just prefer to come in and no matter what... nothing brings it home better than having to sit in a waiting room yourself in another hospital in intensive care (5:20,31-21,17).

Relatives helped us to ‘see’ the person.

Bryce you often find the family will tell you what a person is like (4:3,11) spouses would be the closest, I mean if they're sleeping with them every night in a double bed, and if they've been sleeping there, I mean especially an elderly person, say for the last thirty years, then you've got someone who knows this person back to front (4:3,30-34)

Taylor found if the relatives come in and they're not aware of the environment and they might think they're in pain and they probably know the person better than we do anyway and might, I don't know, sometimes by talking to the relatives you can pick up little things. (9:3,4-10)

Dracup (1988) maintains that it is most beneficial if the patient's relatives are present, talking to and touching the patient. Involving the relatives in care helps them to feel less anxious and provides reassurance for the patient (Calne, 1994; Stanton, 1991).

Asha involved a wife in the care of a dying man. I had that man in bed one and his wife helped me wash him at the end of the night. (2:13,15-17)

However, a French study found ICU staff more enthusiastic about relatives being involved in care of their loved one than the interest relatives showed (Azoulay et al., 2003). Families may need to be encouraged to touch and talk to the patient in their usual way (Dyer, 1995; Glide, 1994). Other auditory input, such as music and tapes of favourite TV shows, could be provided by family (Dyer, 1995; Green, 1992).

Having a history of contact with a particular patient enables a building of patient and person knowledge within nurses over time which in turn allows nurses to give individual and appropriate pain care.

Bryce She was quite capable of doing her own actions but, in the opposite way she said "You must hate looking after people that can talk back." and I said, "No" I said, "Quite the opposite." I said, ... "You like to look after people, and **the best you can look after them is when you know what they want.**" So when a person isn't capable of their own actions, you depend very much on other people, including yourself, to try and interpret how they're feeling, like their physical comfort and especially their pain issues. (4:2,21-32) [my emphasis]

Morse (1991), however, claims this connected relationship is not possible with an unconscious patient; the relationship would be superficial and detached, as the nurse meets physical needs and there is no emotional input. From the information revealed in this study, I would disagree with Morse, rather arguing that we can have emotional input into the relationship with an unresponsive patient via empathy and imagination.

The art of nursing is contained in the nurse/patient connection (Cody & Kenney, 2006).

Bryce showed this when he articulated his thoughts on what a long term ICU patient might be feeling. I guess its hard to determine, the longer term patients that get unwell, OK they're unwell to begin with, but their condition worsens, what kind of pain are they in now? OK they're over their acute stage

of someone sort of slicing open their abdomen, but what type of pain are they in now? I mean that's a difficult thing to try and comprehend I think. I think sometimes patients go beyond the scope of our imagination and experience... I guess, hopefully all the nurses there are well enough not to have experienced, OK they may have had a big operation but have they gone into renal failure and have they gone into multi system organ failure, what kind of pain is that? Is there a pain, I mean, there's got to be pain with it, but is it, is it a real sharp pain, is it a dull pain how do we best get rid of that? Do they need, I mean, how do we wear their infusion down to a level that's keeping general body pain not the specific incisional pain? (4:12,3-22)

People who are comfortable with being certain will be motivated to try to become more certain about uncertain situations in order to cope. In order to become certain, they may want to know more about the situation thus becoming clearer and more certain, or they may convince themselves and put on certainty that is not based on evidence but their faith in it makes them sure. By placing great value on engaging or connecting or getting close to patients and their families in order to gain knowledge, become clearer and thus make better decisions, nursing has devalued the avoidance option for coping with uncertainty. I do not think that we can place moral judgments on the complexity of coping with uncertainty. Attempting to connect may give nurses greater insight into this patient and their family, this medical condition or procedure but the uncertainty of what is experienced within the patient now remains and cannot be made certain. Connecting nurses may feel satisfaction that they have done their best but they may become burnt out by the effort or by the frustration of feeling they know different from the doctors who control analgesia. Avoiding uncertainty by looking away to the personal needs or performance of ourselves as nurses or focussing on the rescue of patients allows a feeling of relief from the unobtainable and a move of energy towards those things we can do something about and for which there are some measurable outcomes to show we have made a difference. However, avoiders may miss subtle cues as to what is happening inside patients because they are focussed away and so patient care may suffer. I do not advocate that we are totally uncertain as to unresponsive patients' experience of pain but that we cannot 'know' for sure what they experience. I believe we are able to pick up hints if given the contact time and eyes to see but I also believe we need not stress over finding every clue to the detriment of other priorities and ourselves. Strive for balance.

7.3.3.2 Distance as the balance to connection

Preferring to be distant is one way of coping with uncertainty. It is not as if at these times we do not look, but rather we ignore the uncertainty by creating a false certainty; the picture that forms in our mind is enough. At these times we rely heavily on case and patient knowledge and do not connect closely with the individual because we cope

by ignoring the possibility of uncertainty. Distancing from patients can also help us to cope with the demands of caring and with our humanness in that it is impossible for us to be all things to all people regardless of our own needs and our emotional response to others (Ashcroft et al., 2007).

Sometimes nurses cope by psychological distancing when having daily contact with people in pain. This is achieved through minimising the inferred pain and distress thought to be experienced by the patients. This may be related to the psychological mechanism of selective inattention which enables individuals to ignore things that may cause them to become anxious. The problem for nurses arises when they use psychological distancing and end up not being able to notice their patients' distress enough to be effective in relieving it (Davitz & Davitz, 1980). "Depersonalising and objectifying the patient may serve to locate the possibility of tragedy outside one's own life and community" (Benner & Wrubel, 1989, p377).

An emphasis on nurses' professional roles and responsibilities in the literature has resulted in less information about the humanness of nurses (Taylor, 1992). Nurses are assumed to somehow be stronger than the rest of humanity as it is their role to help others in life processes. Nurses' humanness can help in connection but can also hinder ideal care when nurses' needs are not met. Bond (1988) asserts "...we have a profession of human beings daily confronted by the most emotional of life's events, all striving to hide the one thing we have in common, our humanity. Pretending not to be the one thing that is inescapable, i.e. human, puts severe strain on nurses"(p15).

Davitz and Davitz (1980) acknowledge that nurses are seen by society as 'above' human feelings like anger, dislike or sadness, especially while they are on duty. Drew (1986) talks about nurses being required to be compassionate, patient, and committed day after day. "Humanizing health care cannot be for patients only but for caregivers as well. More attention can be given to the emotional needs of caregivers so that they in turn will have emotional reserves with which to provide patients with confirming care." (p43) Larson (1987) and Benner and Wrubel (1989) found nurses are involved in one-way giving and sometimes need to be cared for themselves. Environmental stressors, which effect nurses individually, such as physical tiredness, as a result of shift work and the physical demands of nursing, can also impact on caring by lowering motivation and eventually contributing to 'burn-out' (Harma, 1993; Kaliterna, Vidacek, Radosevic-Vidacek, & Prizmic, 1993; Lau, Chan, & Chan, 1995; Menna-Barreto, Benedito-Silva, Moreno, Fischer, & Marques, 1993; Nugent, Glass, Krishnan, & Bingley, 1992;

Robinson & Lewis, 1987; D. White & Tonkin, 1991). The physical state of nurses varies between nurses and within each nurse over time. For nurses to look away from patients to themselves may require distancing through not looking after the same patient all the time, breaks, chatting to colleagues and sitting down when tired.

Shiftwork, especially at night, causes changes in circadian rhythm and usually results in less sleep. Performance may then deteriorate (Benner & Wrubel, 1989). "An approach which involves a focus on tasks, routines, and 'doing to' offers protection when the demands of caring seem too great" (Forrest, 1989, p818)

Asha admitted that on occasions she preferred to rest than do extra nursing comfort measures for these patients. I'm sitting here feeling terribly guilty 'cause you know you get your patient turned and settled as quick as you can so you can sit down. Really, its terrible. (2:15,33-35)

Within our unit, time is not usually available for involvement or close connection as nurses are allocated care of different patients each shift. Administrators consider nurses to be interchangeable and that the care plan will ensure quality care. Morse (J. M. Morse, 1991) claims that in a caring relationship, care givers are not interchangeable; she compares this to counselling where there needs to be consistency. Caregiving breaks down with multiple caregivers (van Hooft, 1987). Walters (1992) found the experience of being an intensive care nurse involved being busy. The pace of the work and involvement with technology can impede connection (Barnard, 2002; Fanslow, 1987; Wilkin & Slevin, 2004). The patient and the machines can together become one clinical picture (Almerud, Alapack, Fridlund, & Ekebergh, 2008).

Taylor related the 'doing to' patients that at times substitutes for the 'being with' of caring. Sometimes you don't even think, "Are they in pain." you just get on and do your job, you know, they look comfortable and they're not communicating, so you know, especially if they're on an infusion, you just don't bother, you just forget it like, that issue's been dealt with. I think a lot of nurses don't really think, "Oh but yeah, is my patient in pain?" like. (9:20,26-33)

Asha found doing tasks not adequate nursing, when it replaces caring. I think it's a big problem and I think the key thing is just to be aware of it as you possibly can 'cause people don't, they forget. (*Because they're honed in on the machines?*) Yeah, and getting that tube out or weaning the ventilation. (2:13,34-14,1)

Sometimes referring to patients as cases or bed numbers results in nurses effectively losing sight of the person (J. M. Morse et al., 1995). This interferes with caring.

Asha told of an incident where she acted in a manner that would indicate a lack of care from the patient's point of view. I remember turning someone and the wardspeople were in a hurry, it was like the wardspeople came up from the wards, and they were in a hurry, so we turned my patient and my

trachy tube nearly came out, 'cause I was in a hurry and I didn't communicate with the patient, and the patient was trying to tell me that something was wrong, and I didn't listen to the patient, I was too worried about getting this patient just turned, again its a task thing. I had to turn the patient and that was that... I think we get harassed by other people too, we all do and we do it to people I'm sure, everybody does it, you know when they're trying to turn someone and the patient's just coughing and gagging, sputum's pouring up the tube and, you know, you often say, "Let's stop, suction the patient and we'll go on then." and, you know, the wardy or whatever says, "No, come on, come on, I've just got to do this." or x-ray says, "Look, can we just take this x-ray?" and, you know, it takes a bit, I guess its age as well, you know, a bit of maturity and confidence to say, "No, I'm going to suction the patient." and, you know, there's times where you've had to do, where I've had to do that and that's the big thing that we're patient advocates. (2:6,2-11,16-29)

Minimising can be a sign of disconnection, indicating a lack of sensitivity for what the patient is experiencing.

Leticia thought about suctioning, sort of the easiest and you just go and do it, you know that causes them distress and that's always when they want to get the tube out and move around, like you can do most other things to someone and they tolerate it but suctioning is something that's just horrible, and you just go, "Oh, a bit of a cough coming up now.", and ram this tube down their other tube (1:10,11-18)

When nurses perceive that we cannot provide the care that patients' need, if the workload has a high nursing intensity, there may be feelings of chaos and not being under control. According to theory, to be a 'good nurse' is to care for patients' needs. In the reality of practice, nurses have to divide their energy between all the competing demands as well as look after themselves. (Fagerstrom, 2006)

Distancing may protect nurses from pain but inhibits their knowing the patient, noticing and attending to changes (Benner, 1984; Polanyi, 1962). If the nurse is distant from the patient, the patient is denied an advocate and nursing as a profession is impotent (Gadow, 1989; J. M. Morse, 1991).

Emotional caring can be influenced by unattractive patient characteristics (Kahn & Steeves, 1988). Like or dislike on the part of nurses towards patients and their families stems from issues of respect and judging different types of people based on external appearance, previous experiences, similarities to loved ones or similarities to self. Attractiveness of patients and their families to nurses may draw into relationship or prevent relationships forming (Soderstrom, Benzein, & Saveman, 2003). Nurses are supposed to behave more altruistically than this but that dismisses their humanness. The nursing profession discourages too close a bond being formed within nurse/patient and family interactions on the premise that emotions get in the way of wise decision making.

Robyne spoke of different feelings of care depending on patient characteristics. I often feel when we have patients like drug addicts who are in, I mean, I do give them pain relief but I feel negative towards them, I would say. So that's probably, maybe a personal thing for me. (*Feeling negative towards them, what does that make you want to do, like give them less or more or.. (4 sec pause) just a feeling.*) I think I would do it anyway, but for someone that I feel really compassionate towards and really like, I mean generally, you know, you like all the patients, but if it was like your mother in that bed, you'd be wanting to do absolutely everything for her. The level of care you'd give her would be much better than Joe Blow off the street, that's all I'm trying to say there. And the patient that comes in and, for instance on night duty there was a guy once with HIV who ripped his cannulas out and was like spurting them at the ward staff and jumped out of bed and said, "I'm going to give this all to you." and swearing, and well, you don't have much empathy for someone like that really. And its like, "Well, OK, go. I don't care, leave." You know, its hard, and, I don't know, confused patients that say hurtful things, just have to like take it with a grain of salt. (3:9,29-10,17)

Nurses are sometimes impeded in their care by the patient.

Robyne's patient did not comply with our comfort routines. He'd been on his back all day because he was so difficult to turn over, he wanted to keep on his back, he didn't want to get off it. (3:11,8-10)

The human reaction in nurses to patients who prevent nurses carrying out their duties is to view patients negatively (Kelly & May, 1982).

Especially in acute areas, nurses are faced with a breakdown of caring in the form of violence, abuse, and loss of self-care. Stresses of status inequality, staff shortages, work overload and underpay are accentuated when nurses are without authority or recognition for their life and death responsibility. "The stresses of nursing become intolerable when the demands of the situation prevent the nurse from performing with a maximum level of skill and compassion" (Benner & Wrubel, 1989, p369). Would nurses cope with these stresses if the primacy of caring could be uncovered in society and nurses had adequate pay and conditions for their level of responsibility?

Keeping a distant patient relationship is beneficial in that it protects our psyche from disintegration when our work confronts us with physical trauma and emotional crises, but distance is detrimental when we miss 'seeing' the person who is the patient. The uncertainty surrounding distance in our relationship with shadow patients involves how much can be discovered about their pain and what harm can nurses avoid experiencing.

7.3.4 About nursing within complexity

When nurses understand themselves and accept the personal complexity we manifest each day, we can thoughtfully approach our work rather than unknowingly react.

Tiredness, like or dislike of patient or their relatives, emotional fragility, being tidy or

organised, believing the measure of 'good nurse' is finishing work, wanting peace and thus not wanting to 'rock the boat' all impact on the way nurses will approach pain care. Being human and having personal needs has traditionally been viewed negatively in nursing through the tradition of the church and army. I believe there is no need to feel guilt over meeting personal needs, rather, nurses who care for themselves can better care for their patients.

To work well within complexity would involve less reacting and more choice in responding or initiating interaction. The idea is to 'know' ourselves and others in order to be more thoughtful when contacting others. If we have insights then we can be more empathetic, we can do right or at least cope. Hearing others' stories, giving understanding and consideration to ourselves and the 'other' we come in contact with, having respect for each other and moving towards a mutually agreed upon end point will help us work together more as a community. I aimed to reveal individuals, groups and their interactions with each other so that nurses might 'see' what was happening when they considered unresponsive patients' pain.

A way to visualise the complexity was described by Fagerberg (2004) who likened nursing to the metaphor 'the weave' where the warp was created by the organisation and the weft by the interaction of players in the patient's care. The individual attributes of nurses are the treadles that make the pattern in the weave. Different patterns emerge depending on nurses' use of self. In Fagerberg's metaphor, the shape of nurses' patterns will depend on their locus of control.

Nurses' best way of coping with uncertainty is to be aware of, allow for and live within complexity without feeling the need to 'fix it'. The pull is either to do nursing tasks without involvement or to really try and get inside the patient to try and work out what is going on for them. Healthy coping puts us somewhere in the middle of these two extremes. Commitment, seen in actions and attitudes, can be to: treatment goals, patient or nurse's self. A wise nurse will balance priorities (J. M. Morse, 1991; van Hooft, 1987).

7.3.4.1 Voicing

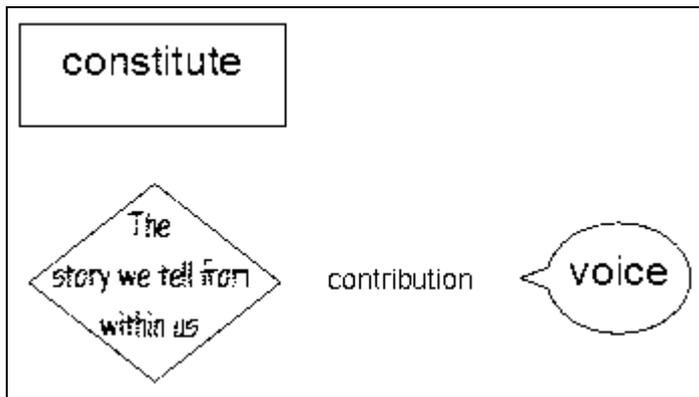


Figure 7.3.7 Contributing through telling

As narrator of our practice, the story I am telling in this section is the nurses' sense of relationship with the patient. In order to interpret patients' pain and in order to respond and provide comfort, nurses give these patients agency through how they 'see' patients. Agency is the picture we draw on the slate based on our assumptions [putting ourselves in their place or judging what we think would be the best for them], our knowledge, our experience with other awake patients in similar circumstances and what the relatives think. Valuing the nursing role, medicine, relatives, previous patients and knowledge then hold all this together for this patient. Nurses are storying an active relationship of care where they interpret the agency in order to care. Chiarella (2002) admits that there is little support for independent nursing moral agency. Varcoe et al (2004) found that nurses practiced cautious agency within the constraints of their practice situation and were often 'torn' in trying to do the right thing. As nurses contribute by telling their story the whole multidisciplinary team will benefit from the holistic view and patients will have a greater chance of receiving optimal care.

Kathryn Gambling (2004) was interested in the concept that nursing is an art. Gambling investigated the context of intensive care and elicited patients' stories to find themes of artful practice in nursing. The themes from Gambling's work include *perpetual presence* [nurses' availability and vigilance - "in good hands"](p387), *knowing the other* [personalisation of care - "going out of their way"](p389), *intimacy in agony* [respect for the interior suffering and reaching out in with human caring - "don't write me off"](p390), *deep detail* [attending to taken for granted basic human functions - "your throat and mouth are so dry"](p391), and *honouring the body* [handling patients' bodies with dignity - "caressing me into the chair instead of heave ho up and down"](p392). Gambling did not find patients mentioning technology in ICU as a form of

dehumanisation, rather, the way nurses interacted with them made the difference in their ICU experience. Gambling suggests nursing art is about attunement rather than nursing activity.

Nurses can grow in significance from fulfilling the roles historically in place or those mandated by the profession and then nurses can contribute by achieving connection with patients in our work and also with those willing to listen to our story of 'being' an ICU nurse considering unresponsive patient's pain (Robbins, 2004).

7.3.5 Summary

Because we are all human beings with faults, foibles and unique personalities, with finite bodies, energies and attention spans, we are not the same entity at all times, we are changeable and ever changing. The story that we tell today is frozen in time and a snap shot of the possibilities that we 'are', but we will not remain that way after the telling. The characters in this story, doctors, nurses, patients and relatives, are changeable, so even though generalisations are made, the relationships are fluid. Like and dislike are woven into these relationships and impact on how these characters act.

Coping though false certainty and relinquishing responsibility are somewhat useful in preventing our psychological disintegration, but coping by being aware of, allowing and living within complexity provides better outcomes for both nurses and patients and allows us room for movement towards ongoing improvement in our practice. The next section 7.4 discusses how telling how it is for us through stories would be a way to use this study and move our practice forward.

7.4 Storying – *'telling' of practice*

Stories can generate an interest that pulls attention through our emotional response and as such they can be a powerful form of communication. Valuing the storytelling that already informally exists amongst nurses and providing a place and time for more formal expression and explanation of nursing practice are ways of encouraging and accessing new knowledge and ongoing support for each other. New knowledge comes through telling our story and the story we live within so that we might be empowered to make a story happen. Support comes through the psychological release of expression, of being heard, and thereby meeting our need to grow and contribute.

...to see wisdom as consisting in the ability to sustain a conversation, is to see human beings as generators of new descriptions rather than beings one hopes to be able to describe accurately (Rorty, 1979, p378).

My suggestion is for us to enter a more systematic formal dialogue where there is storytelling for explanation and expression, where we value our nursing, and where we can take on board the responsibility to make our story happen.

This section 7.4 is a synthesis from nurses’ words, the literature and my understanding of the place of stories in nursing, both formally and informally, as a way to hear nurses ‘voices’. Telling stories requires the courage of nurses to tell, a space to say and a respectful audience to listen. Storytelling is a way to communicate complex knowledge as a way of developing nursing practice. In this way nurses can fulfil their need to grow. Expressing ourselves through storytelling is a powerful way to reveal the depth of nursing complexity. In this way nurses can fulfil their need to contribute. This section presents the option of storytelling as ‘voice’ to put in place ways of meeting nurses’ six human needs in terms of formally applying concepts from the dialectical narrative situatedness schema.

So that the thought content can be easily read without distraction from the oral form of expression, quotes from the transcripts have been ‘cleaned’ [notations reflecting speech removed].

7.4.1 About the concept of ‘voice’

The concept of ‘voice’ has been used extensively in feminist work to indicate the talk and stories of people who have not previously been heard. One goal of feminist work is that all members in society have a ‘voice’ that is heard so that each can participate fully in community life (Gilligan, 1982; Rakow & Wackwitz, 2004). Participants raised the issue of doctors not listening to nurses at times.

Toni You say, and then if you could, if they [**doctors**] would just listen to you a bit more I think cause you’ve been there all day and you know how your patient is (6:6,32-7,2)

Taylor So people just weren’t bothering and I remember he had huge big pressure areas like gapes in his bottom and we would just insist that, you know, the doctors wouldn’t write anything up we’d have to go and ask them before his dressings. We were giving him something and he would still, you know, he would get (*Tense*) yeah (9:19,30-36)

Belenky et al (1986) portray a development of stages in women’s ‘knowing’ in terms of ‘voice’. Speech metaphors were an important part of the women’s words and represented the women’s lives and experiences. Belenky et al categorise the stages of ‘voice’ as:

1. Silence – feeling ‘deaf and dumb’, obedient to authorities

Taylor I haven’t been working long enough to know the levels to give, if you know what I mean? Like I’d probably think, “Oh well, the doctors ordered that, I shouldn’t question that (9:10,26-30)

2. Received knowledge – looking to others for knowledge or to define their role

Bryce but I mean, and you can see it, you can see someone come along, and if you ask someone’s opinion too, some people, there can be a difference like three or four mls an hour which is a fair bit, I mean, that’s a lot when you consider it over say (24 hours) I mean even two mls over 24 hours I mean that that’s 48 mgs of something, that’s a lot of relief, but that’s subjective, obviously that person either feels that, “No, he hasn’t got any pain.” or “God, he must be in a lot of pain with that.” (4:13,20-30)

3. Subjective knowledge – beginning to listen to the voice within

Asha I remember one night having a screaming argument with the registrar in another ICU I worked in because he just wanted to give a tiny bit of morphine to a paralysed patient and saying, “You have to give them something sedative as well, you know, all the narcotic will do is just make them drowsy. You can’t paralyse someone” and we paralysed this patient just on a bit of morphine and we just had this screaming tachycardia, went really hypertensive and I just said, “We we’ve got to give them something.” (2:8,27-35)

4. Procedural knowledge – practising reasoned reflection

Taylor I haven’t done many oesophagogastrectomies, the two or three that I’ve done now, when I’ve looked after have been extremely painful, and, so that’s what’s in your system to go on, like that type of surgery must be very painful, especially for suctioning. (9:22,17-22)

5. Constructed knowledge – seeing the contextual nature of knowledge

Leticia once you do the course you have a greater medical knowledge and knowing the consequences with people’s haemodynamic status like if they’re a bit hypotensive that you may not give them such a great bolus of morph and midaz, or you might give them morphine and then give them the midazolam a bit later on or vice versa, ‘cause having experienced people losing blood pressures and things like that because you give them both at once or whatever. So seeing things like that happen you think, “Oh my gosh, I’ve got to get this patient’s blood pressure back up from 50, teaches you not to do that as well or to think twice about doing it and look at their condition as a whole picture and not just “oh, they’re in pain”, but looking at it in the context of where they’ve come from, like whether they’ve just come back from theatre and they’re hypertensive and so by giving them you’re going to treat their blood pressure as well, or if they’ve just had a massive haemorrhage you know you want to keep them pain free as well, that sort of thing. (1:7,29-8,10)

Belenky et al’s work relates to my schema of nurses ‘voicing’ within the constitutive/constitute dichotomy. Instead of nurses moving through distinct categories of voicing as a progression, I conceive that they voice expediently. Expedient voicing is the pragmatic use of sharing knowledge and feelings, or remaining silent, that results in the desired outcome.

Beth what the doctors say, you have to go along with it otherwise “you’re rocking the boat” and upsetting everybody. (7:7,406)

Toni Because they wanted to see if he was alert and orientated ‘cause they were worried (to assess his head) yeah. But you can see their reasoning behind it but then you can also say, “Well, if he’s in pain, you know, he

shouldn't have to be lying there in pain when you're turning him and those sorts of things, just to make sure that his neuro status is OK." But its sort of, you just don't, you know. Well yeah, its hard I suppose, what's the priority really? (6:5,4-12)

O'Reilly et al's (2001) concept of 'voice' covers the idea of seeking and expressing knowledge as well as showing situatedness and perspective. O'Reilly et al also include in the concept of 'voice' expressing as well as listening. This aligns with Belenky et al's work where people draw on external knowledge or instruction especially in stages one and two but gradually integrate knowledge from within themselves. In my conceptual schema, 'voice' represents listening and speaking. I have aligned listening with 'constitutive' as we receive information from external sources. I have aligned speaking with 'constitute' as we tell of knowledge and feelings from within ourselves.

Hannah Arendt developed the concept of political agency which feminist work has attributed to 'voice' (d'Entre ves, 1994; Moruzzi, 2001). Political agency refers to the degree to which a person can participate in the society; have a say in the arrangements we live within, that we can make a difference.

Asha has a full understanding how fulfilling her role would make a difference. I think, we forget we're nurses, and nursing's a skill on its own and I can't define it, I don't know how to define it; its about people, its not for us to diagnose or to treat, you know, prescribe drugs or treat disease processes, that's what doctors are for. We're there for patients' comfort, and a lot of things, you know, to coordinate all the multidisciplinary teams that we have, but, most of all we're there for patients' comforts and I think that's our skill, looking at the patients, trying to get them comfortable, and safe, I mean safety patient safety has to come first as I said, but there's other things too. The patient first and foremost. (2:4, 18-29)

7.4.2 About the power of story

I will promote 'story' as the vehicle of expression and explanation for 'voice' to maintain the congruence with the narrative nature of the study. Additionally, the universal nature of storytelling means that stories are accessible and user-friendly, although there are many other ways to 'voice'. Stories have been claimed as central in defining our humanity (Gordon & Alexander, 2005). Nurses have stories to tell and yet publicly available nursing stories of practice are few (P. Benner, 2000; Gordon, 2005). Storytelling allows insights into the complexity of practice (Bailey & Tilley, 2002; Bond, Mandelco, & Warnick, 2004) yet also reveal the personal meaning of the vital and distinctive caring of nursing (Hudacek, 2008).

The power of a story for grabbing attention usually relies on the content being a remarkable event, how it works within the surrounding conversation, the entitlement of the speaker to tell the story and the interest level for the audience (Labov, 1972). Stories are used by: tribes to pass on knowledge over generations, theatre, movies, novels, preachers to highlight points in sermons with anecdotes, in nursing lectures, clinical learning and professional development. Stories can be potent tools used to persuade or influence others or they can be used to promote sameness in community (Pinkerton, 2003; Smeltzer & Vlasses, 2004).

Hannah Arendt developed Kant’s concept of the universal being contained within the particular. We can relate to a particular story because that story contains universal truths that we know ourselves because we have experienced them as well (Beiner, 1982; d’Entreves, 1994) The emotional pull of individual stories relies on us imagining that story to be happening to us. The media and charities use the technique of presenting an individual story to have emotional sway.

Stories have the capacity to cater for complexity and nuances and time; past impacting on present looking forward to future. The form a story takes is as important as the content for revealing ethical meaning (Finder & Bliton, 2001). Stories guard against the tendency to reduce life into simplistic formulas. Personal stories are credible, believable and worth remembering. Stories can be a way to reach closure for the teller, resolve conflict and decrease burnout (Kooker, Shoultz, & Codier, 2007; Weber, 2005).

7.4.3 About the space for stories

Within the current culture of evidence base for practice, storytelling is not a tried and true way of generating new knowledge. However, not all practice situations can have statistically significant research to underpin them and clinical nurses find difficulty engaging with complex academic research (Rycroft-Malone, Harvey et al., 2004). The dialogue on evidence-based practice has been opened out to consider knowledge generated from clinical experience, patients and others involved in the care situation, and the context to be evidence-based in addition to research (Rycroft-Malone, Seers et al., 2004).

Because stories are a way to get close to what the practice of nursing is in all its complexity, I think we need to be able to tell our stories in an accepting and supportive and maybe more formal context so that, in understanding what it is that we do, new

nurses might learn and others might respect our work. However, we need to trust each other and be caring to each other in order for stories to be forthcoming. Without an environment of trust stories can remain hidden, especially if these stories do not align with the current dominant story of the group or culture.

In addition to a physical space for stories, there needs to be time. Stories have a temporal nature by virtue of the fact that they relate events of the past in reference to the present and look forward to the future. There is a temporal nature to the way we relate to each other. There is more to the contact between people than a beginning, middle and end just as there is more to a story than a beginning, middle and end. Each contact is influenced by the history of contacts and this contact will in turn influence future contacts. How much time do we take? In relation to power dynamic and respect will depend on how comfortable we are to share our story with others. Powerful others can limit the time in which we are allowed to speak.

Valuing the storytelling that already informally exists amongst nurses and providing a place and time for more formal expression and explanation of nursing practice are ways of encouraging and accessing new knowledge and ongoing support for each other. Nurses come in relationship with each other as colleagues, teachers, managers, role models. Making a community, rather than bringing together a collection of similarly situated individuals, requires respect amongst the members towards each other. It is unfair to only expect doctors to respect nurses' point of view, nurses have a responsibility to respect themselves so that they take responsibility to communicate their view and are not subversive. We need to respect each other as nurses and not criticise each other, rather, realising we are human, work towards ensuring a caring community in which to work.

Marsden (1990) argues that collaboration would be fostered if there was an ethic of community within patient care units, where ideals are held up, order is maintained, and history and tradition are shared through storytelling.

If the unit is looked on as a community, then it follows that ideals will be fostered in every person who is part of the unit-community. These ideals would include commitment to the unit, effective communication skills, clinical competence, treating patients, families, and other staff members with respect, and a collaborative approach to patient care that includes personnel at all levels. (Marsden, 1990, p423)

Nursing and medical stories transmit and reinforce values. When changes within a unit occur, stories are retold to convey traditions and ideals of the unit and can also relate commitment to the work nurses and doctors do together.

We need to increase our public storytelling to see how the tension between caring and curing is navigated. Storytelling could show how 'knowing the patient' is more beneficial than breaking down practice to make it more efficient (Patricia Benner, Tanner, & Chelsa, 1996). However, the more explanatory forms of knowledge are usually valued more.

We need a respectful space for stories to be forthcoming. Showing respect to other groups and individuals flows out of the respect we show to our own group and ourselves as individuals. Respect allows freedom in giving and receiving information and helps understanding to develop. This understanding is a positive thing to have because it allows us to approach each other and interact in appropriate ways which lead to better outcomes.

If we are intimidated by power we may approach powerful people timidly, conversely, people who appear confident may be wearing a mask based on the belief that they must be all-knowing. What face do we show the other? What is our internal motivation? Nurses 'voice' includes the choice of silence as well as speaking and listening. When faced with the possibility of ridicule or retribution, nurses have a history of not speaking up. However, nurses also need to become more confident and robust so that the words they have to share are put out there to be heard without wrapping the nurse in cottonwool.

I want to encourage nurses to give 'voice' to knowledge, give 'voice' to feelings, to value the way stories are currently used and to be open to the way stories could be used. Nurses need to overcome 'voice' tensions so that they have courage to say, space to say and respect to be heard.

Therefore, a way forward from my research could be to establish nursing practice development activities in such a way as there was storytelling within a group of similarly situated individuals where issues of concern regarding practice would be raised and the group would come up with strategies to implement and assess outcomes in a continual process. The group would decide on involvement with leadership or other such groups and would also decide on ways of measuring effectiveness.

The interviews were a mini trial run of new knowledge coming from storytelling. Similarly, new knowledge would come from interaction that would occur in such a group but be facilitated with the understanding of interrelated concepts. The presence of a dedicated facilitator may be critical for enabling in terms of being an agent for change (Rycroft-Malone, Harvey et al., 2004). Similarly to the co-creation of stories within the interviews of this study, the facilitator by sharing of themselves would enter into the co-creation of stories within the group (Smith, 2006).

Valuing the sharing of workplace learning through nurses telling their stories is a way to promote professional development (Jantzen, 2007). McAllister and Osborne (2006) used a formal nursing practice development setting to equip nurse educators to be facilitators of change. The workshop integrated principles of transformative teaching and learning with narrative elements such as the use of metaphor and discussion around a case study of change and community development. I would want a facilitated storytelling place to be more clinician driven in terms of topics and outcomes. Storytelling amongst nurses has the potential to attend to the three advanced practice development goals of artistry, knowledge generation and critique (Higgs & Titchen, 2001).

7.4.3.1 Facilitating a formal storytelling space

I envisage a group of similarly situated individuals in systematic dialogue about the concepts of Figure 6.1.1 to holistically attend to core human needs of nurses. Attending to the needs would mean nurses would want to put in effort and stay in their job. This is a different and more organised process than the unstructured nature of finding an inviting and safe place to share stories. At the level of expression and finding depth, unstructured storytelling can bring to light whatever nurses want to share and would be valuable. In an unstructured storytelling session the facilitator could extrapolate out to the four corners on the run, however, following my conceptual schema would ensure a comprehensive approach. However, I want to comprehensively cover all the concepts and not just rely on gaining more external knowledge.

I would prepare for a session by asking for a topic. The topic would be approached from four directions; each of the four corners of Figure 6.1.1. Concluding each of the approaches would then be bringing the discussion through 'voice'. I will show an example of an imagined session about the topic of midazolam using nurses' words from the interviews of this study. We did not look extensively at midazolam because the

topic of the study was pain but the nurses brought midazolam into the conversations and so I thought it would provide an interesting example of how I would intend the process to play out.

7.4.3.1 (a) Constitutive/head

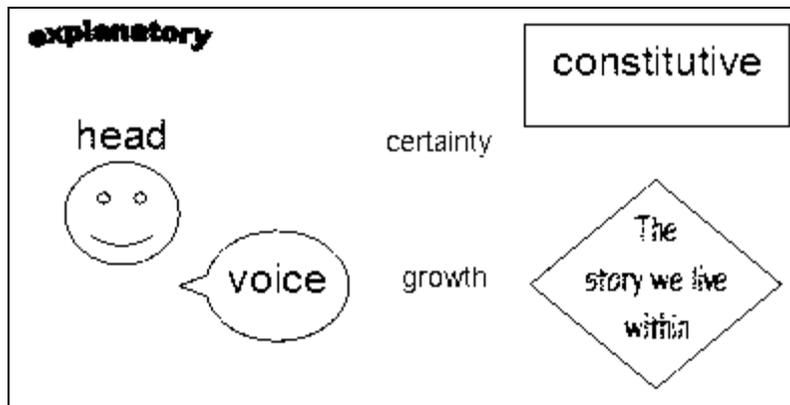


Figure 7.4.1 Top right quadrant

I would start at the top right of the diagram because it would be less confronting at the beginning of the session for nurses to talk about external sources of knowledge; information that we have about midazolam that has come from outside of us. What are the metanarratives that surround midazolam or the way we are to handle it? It would be worthwhile to handle this information from a critical stance in terms of the reliability of sources. The intent is to increase certainty. This process in a small way mirrors ‘evidence’ but the difference being that the knowledge of the group is under discussion; what ‘is’ known in light of what ‘should be’ known. We might ask who determines what we ‘should’ know.

This segment of the schema seems cyclical in nature. We gain knowledge by using the listening part of our ‘voice’ to receive from the ‘voice’ of the source. Then, in the process of speaking about our internal knowledge we have gained from external sources and critically looking at those sources, we are becoming an external ‘voice’ for other nurses.

Our unit routines determine midazolam to be the most commonly used sedative and therefore it is the sedative we work with the most. Should we find out the current thinking on available sedative drugs and then assess whether midazolam is best – or do we leave that to the doctors? Should we consider cost or user-friendly packaging – or do we leave that to management?

Petra its usually morphine and midazolam in most cases anyway, and that sort of covers your pain and your um sedation. (10:3,18-20)

Patrick I think that those people who will be, will always have a, like a morphine and midazolam infusion up anyway (5:2,7-9)

Midazolam is prescribed and ordered by doctors. Do we enter into the possibility of nurses having prescribing responsibilities – or do we leave to the professional nursing and medical bodies to determine the rules?

Beth when they come back from theatre and they're not responding but they're very hypertensive I find that a lot of the anaesthetic registrars will immediately say, "Morph, Midazolam and" (*First*) and its yeah, just a way of settling them down too and they're obviously, you know, the patient's obviously in pain although they haven't been reversed and sometimes I'm even tempted to even have it there ready because you know what's going to happen (7:7,19-29)

Midazolam is an S4 drug that is required to be locked up. Do we question the need for midazolam to be locked – or do we leave that to the pharmacy administration? Do we revise the way we gain access to the locked cupboard, who carries the keys and the process of legal checking – or do we leave that to the nursing hierarchy?

Leticia when you first start in the unit when you come from a general ward situation its a big hoo haa about giving S4's and S8's and that sort of thing and so, like for me, I was quite paranoid about giving it and you gave it very carefully and in small doses and you triple checked it and all that sort of thing and then to come into an environment when it's used so often and so liberally was quite a change in attitude (1:6,26-33)

Midazolam is considered addictive and so the use is limited in quantity and length of time. Should we know amounts of midazolam and lengths of time that would cause addiction – or do we leave that up to the doctors?

Rhea they tried to wake, withdraw morphine and midaz and stuff like that because of long term use (*to wake him up*) no, because of long term use and withdrawals (8:11,8-10) If you've been on long term midazolam, or may be its because its a combination of midazolam and morphine and its more the withdrawal from the midazolam, but that's what they put it down to and they do try and stop it completely and I know that's what they were doing with P. A couple of weeks back, and his tremor, although he had it pre op, but we didn't see, his friends and family said he did have a bit of tremor, but his was really noticeable and they were putting it down to withdrawal. But it would have to be a combination of morphine and midaz. (8:11,19-30)

What are we being told? Are we being told how to think?

7.4.3.1 (b) Constitutive/heart

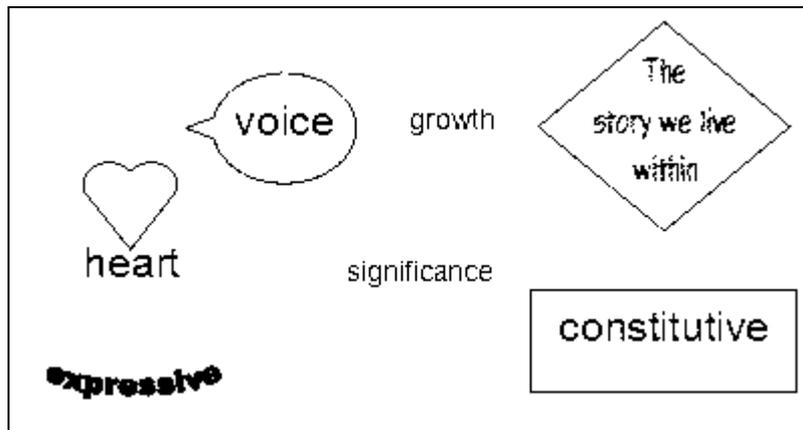


Figure 7.4.2 Lower right quadrant

I would move the discussion to the lower right of the diagram because while still in the realm of what external sources are telling us, the content will be about our ‘being’ which is closer the core of us and elicits emotional responses. Sharing of emotions would need a feeling of safety within a group of nurses for it to be beneficial. The form of delivery of matters of the heart would be expressive. What have others told us or expect from us about ‘being’? How do others bestow significance upon us?

We have the autonomy to use midazolam as a tool to produce the desired result of patient sedation. It is easy for nurses to be in control of midazolam and in control of the patient. We can learn about how to ‘be’ by watching other nurses in their ‘being’.

Leticia I just remember seeing this patient leaping around in the bed and all of all of us were trying to hold him in, and she just grabbed one syringe after the other and just plied all this midazolam into this patient and I just remember standing there and being shocked at how easily it was given and seeing things like that I just thought, “Oh well, it is okay if they need it well I’ll just give it.” And just asking people when you’re not sure, “Do you think I should give this do you think I should give that?” And then realising further down the track that its okay to try it and if it doesn’t work then you get something else, but if it does then you have the autonomy to do that and you can do that quite safely. (1:7,16-29)

We have a comfort providing role and when someone is dying we can use midazolam liberally, within doctors’ orders, to provide comfort. How do we learn our comfort role? How do we learn how to ‘be’ in relation to patient death?

Toni we decided on my shift that they were going to withdraw treatment and put him on trachy mask and things, and we just kept giving him heaps and heaps of morphine and things and lots of midazolam. So I think he was quite comfortable and that the orders were quite liberal, as to what we wanted, and I had no hesitations in giving him, you know, frequent doses, ‘cause he’d got put on the trachy mask, he started getting quite distressed and

you could tell he was just distressed and, you know, uncomfortable. So I had no hesitations and the medical staff were quite happy to keep giving as much as we thought. So that was quite good. (6:17,10-22)

We have an advocacy role and we approach doctors to prescribe when we think midazolam should be used but is not ordered. We may approach several doctors until we get what we want. How do we learn about our advocacy role? How do we learn how to approach doctors?

Petra we had one patient that was quite he was actually quite with it, but with a huge one-sided bleed, I think it was, causing extensive paralysis and damage to most centres but he sort of looked aware and although we sort of controlled his pain to a degree they were quite reluctant to sort of sedate him, although we were, you know, he was incapable of managing his own airway and we pulled the tube with the intension of allowing him to pass on naturally. I mean in that sort of situation I just like discussed it with the doctors and if you didn't get a right answer from one you just went to someone higher up and ended up getting him a midazolam order and in the meantime just sort of keeping his morphine right up. (10:5,23-6,2)

Sometimes midazolam is withheld when it is detrimental patients' outcome. How does the withholding of midazolam as a comfort toll affect nurses providing comfort?

Patrick I had a patient and she was like at the stage where she just couldn't communicate whether she was in pain or not, and we had morph midazolam infusion off because of the renal function and all that, (5:9,17-21)

We feel relatives have an expectation that we will have patients calm and not in pain. Is it really the relatives' expectation or are we putting it onto them? Do we take on the role of 'looking after' relatives as well? How do we learn what pleases relatives?

Taylor it was a head injury, and all his vitals were OK, he was just laying there. He looked comfortable and but the relatives kept asking me, "Are you sure they're not in pain?"(9:4,23-26)

Patrick I guess its something I've thought of and feel that maybe we're sort of delaying the time between the patient arriving and actually letting the relatives in for the relative's sake, to have the patient nice and comfortable and pain free and clean sheet (5:20,30-21,1)

What are we being told? Are we being told how to 'be'?

From a dialogue within the constitutive side of the diagram we can grow, that is, we can critique our current 'knowing' and 'being', we can assimilate new information, or we can come up with more questions or gaps of knowledge that need filling.

7.4.3.1 (c) Constitute/head

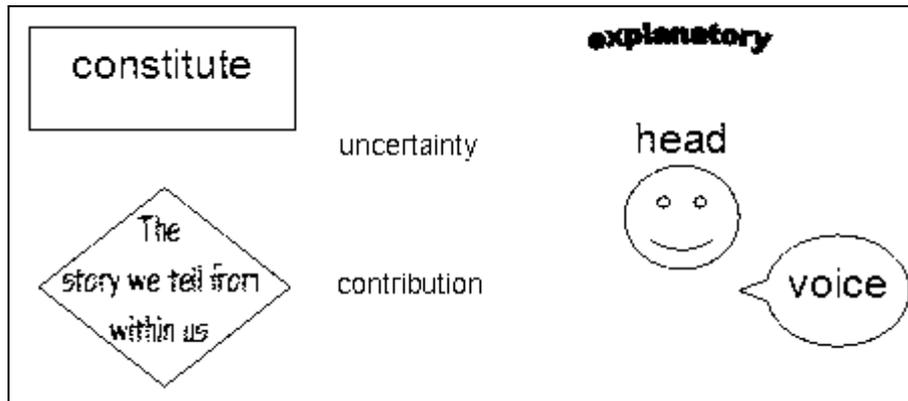


Figure 7.4.3 Top left quadrant

I would move the discussion to the top left of the diagram so that nurses may ‘voice’ their internal knowledge about midazolam. What do we want to say from experience? What do we think? How do we explain the uncertainty? Do we think it is unsafe to be uncertain?

Midazolam makes patients settle and be calm. Nurses know how to settle patients with midazolam through trial and error; cause and effect.

Toni if they're on morph and midaz they're a bit bombed out. (6:3,21-22)

Leticia I think pain is something that they all experience, and discomfort, especially if they're an unconscious intubated patient and I think that its something that you can only manage well when you've had lots of experience at doing it, like I remember when I started in the unit and people were on a morphine and midazolam infusion and they said, you know, keep them comfortable, I had no idea what to do and people just sort of said, "Oh, leave it at two mls an hour or five mls an hour." and there was never any education as to the reason why it was at that point it was only because you ran an infusion at two mls an hour and you saw that they were still awake and uncomfortable and distressed when you moved them that you realised that you should turn it up to five mls an hour. (1:1,36-2,12)

Robyne its always considered, you know the nursing staff always ask, morphine, midazolam, is always, someone's always had it at some point in their admission and its always sort of the first, I think twenty minutes that's dealt with. Whether that's just to settle them in a little bit. (3: 9,16-21)

Midazolam is quite safe to use in ICU when patients are ventilated. Nurses learn that midazolam is safe through seeing a lot given and the patient still live.

Leticia they were quite happy to give a bolus of midazolam or a bolus of morphine and just give it and it not work and give another one and you know, doctors would say just give them a bolus of this and a bolus of that and seeing that it was okay to give and recognising that they are fully ventilated anyway and this, they may stop breathing but its not going to compromise their lives (1:6,36-7:5)

Midazolam can help with agitation caused hypertension. Nurses learn to sedate first before giving antihypertensive drugs when they see midazolam work in settling and reducing blood pressure.

Patrick brought back a patient from theatres and you know, blood pressure sky high and you sort of immediately go “Oh sublingual adalat or SNP infusion,” and then they sort of, “Ah ah, just sort of give them some morphine and some midazolam and that’ll be fine,” And you just go, “Okay, I’ll do that,” Oh, it really works. (5:8,28-33)

Midazolam can cause hypotension. Nurses learn to be careful in the size of midazolam bolus through seeing blood pressure plummet. Nurses learn to juggle vasoactive drugs with midazolam to maintain blood pressure.

Taylor I suppose like I just didn’t think about I didn’t give, my patient I had over night was on a morphine infusion or midaz but I didn’t give him boluses every time I went to suction and you know they do (*You’ve got to get them to cough anyway so its stimulating them one minute and trying to calm them down the next minute*) Exactly (*you’ve got to weigh up somehow*) And its hard, I mean, this person was on adrenalin too so you’re titrating that as well. I mean their blood pressure would always go up when you’re doing something like that and go back down two minutes later. (9:17,17-33)

Midazolam causes some sort of amnesia and we would prefer some patients not to remember what they went through in ICU. Nurses learn about amnesic properties of midazolam from patient anecdotes.

Asha at other places I’ve worked just to remind medical staff to perhaps give some sort of amnesic agent, (2:12,26-27)

Asha “was that was she on midazolam or any sort of benzodiazepam?”, and they said, “No, that was after she’d come off the midaz, she can’t remember anything from the time she was on it.” (2:12,20-23)

I thought *At the time it could have been really horrible and then because you’ve been given midazolam you don’t remember, which is good for them, I think, its good for them not to remember but I think that they shouldn’t have had to have experienced it in the first place unless it was necessary.* (5:22,7-12)

Toni it would be interesting to see and you often wonder what people do remember when they’re out of it, like whether they actually do remember you going up and saying, “I’m going to turn you now Mr ,” you know, or whether that you just midazolam them out, you just don’t know what they remember. (6:15,7-12)

Toni if they have had lots of midazolam whether they’re just kind of guessing at what they felt, you know, whether they’re just sort of thinking, “Well, yeah maybe I was in pain, or maybe I wasn’t.” (6:16,26-29)

Petra patients that do come back and see you before they go, especially a lot of the head injuries remember absolutely nothing of the whole situation and whether I mean that’s probably a combination of the midazolam as well as just sort of the whole experience. ‘Cause, the way I understand it, midazolam doesn’t just knock off your memory like for five minutes while its working but it has a sort of effect where it (*Yeah, it lasts*) it stops your short term memory of things that have happened sort of in the last hour or so as well. So if you’re on an infusion its just going to keep (*Yeah, wipe*) (10:8,17-19)

7.4.3.1 (d) Constitute/heart

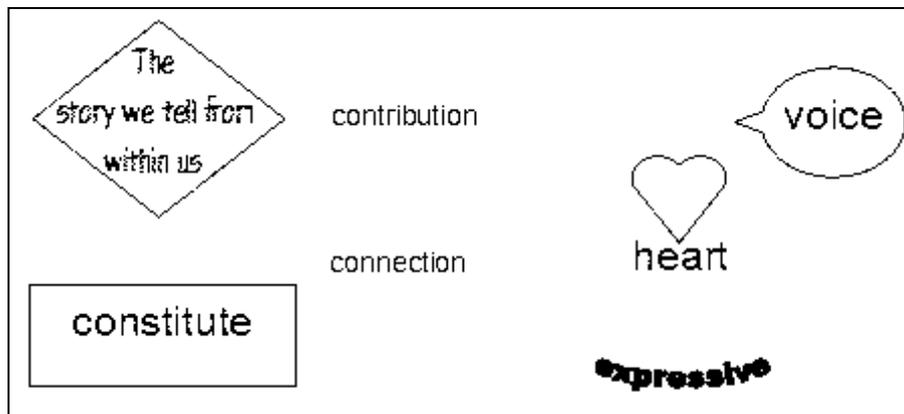


Figure 7.4.4 Lower left quadrant

Finally I would steer the discussion towards the lower left section of the diagram. I would leave this to last because nurses would need to feel comfortable and have rapport with the group in order to be free to express. How do we feel? How does telling how it is for us to ‘be’, in respect to the use of midazolam, help achieve connection? Are we able to make a group story of how it is for nurses? What are we contributing to when we share feelings about midazolam.

Nurses feel in control if we can give midazolam. We feel relieved that we have the resources to get patient looking comfortable and thus proud of being considered a ‘good nurse’. Having a settled patient helps us do a better job – tell the doctors. Nurses are human too and have needs, especially with shift work where tiredness and the energy required to manage a restless patient can impact on care provided.

Leticia it makes a difference when this patient has midazolam, I can keep them in the bed and they will ventilate and that sort of thing (1:7,8-10)

Patrick sometimes we give them a bit of the midaz too. I guess it just sort of makes it a little bit easier for us as well. I can think of instances where you sort of say, “I’ll just give this patient some midazolam so he can get some sleep,” but I think also you’ve very relieved when once they are asleep. (5:10,37-11,7)

When patients are not receiving midazolam we are not bothered if the patient is already calm or we believe midazolam would be detrimental to them. The need for midazolam will not be uppermost in our minds if the patient is calm. It is easy to not think about midazolam if we accept the reason why patients cannot have it.

Patrick I think its this sort of this thing that you’ve got none of your normal indicators that somebody’s in pain, I mean, it slips into the background a little bit, sometimes you even forget the fact that you know that he’s not on morphine or midazolam infusion and I guess sometimes when you’re at the beginning of the shift, and you’re looking through all the infusions, you go “Oh!” you know, “Should I sort of give them a bit of a bolus,” But, to me its a little bit easier because you know, that physiologically it would be detrimental, would further put them backwards if you did have them on a morph and midaz infusion and give them pain control. (5:7,1-15)

What do we want to say? Who do we want to tell?

From a dialogue within the constitute side of the diagram we can contribute, that is, we can share our current ‘knowing’ and ‘being’; we can provide new information. We may examine the origin of our internal knowledge and feelings. How does saying empower us to shape culture or shape our identity?

I have used midazolam as an example to show a trial run of using the concepts contained in the diagram to facilitate an organised and comprehensive look at one topic from clinical care of ICU patients. I used the nurses’ words from my interviews to highlight how such a process would illuminate: the external sources and knowledge content given to nurses to become more certain, the external expectations and roles nurses fulfil to be significant, the internal nursing knowledge from experience that is uncertain, and how nurses feel that can connect them with each other. Through the dialogue process, nurses can grow though receiving and responding to the external input and they can contribute by sharing their internal ‘knowing’ and ‘being’.

7.4.3.1 (e) Expressive sharing and responding

Inside such a session as described above, individual sharing of anecdotes and storied responses may occur in order to encourage nurses to go to a deeper level of dialogue in the form of expression. Nurses may also swap roles as storyteller and audience. This can be cathartic, can establish deeper rapport, and can show deeper levels of complexity.

7.4.4 Summary

The explanatory findings involve our thoughts, our head – things we look for and things we do and things that impact. From our explanations we can appreciate the complexity. The forms of expression let us into our emotional responses – our heart. We feel the difficulty, the frustration and the balancing act we undertake. From the expression we can appreciate the uncertainty.

I was intrigued by the conundrum that in a place of measurement we could not measure pain. I wanted to be sure. Others seemed sure. I ask them to tell me about it. They told me in stories. The stories rang true because I have lived them or seen others in those stories. I grasped rationale for decisions and I felt dilemmas and tensions. We convince ourselves that we know or we put patients' pain aside at times so that they might live or so that we might cope. Sometimes we are content not knowing. Maybe we can help those "Measurers" amongst us to go with the flow. Maybe we can help those "Distracted avoiders" to focus. Maybe we can help those "Unwilling torturers" to get a bigger picture. Maybe we can at least feel not alone in this. Maybe we can value connecting with each other through stories. If we want to, we can make changes to these stories.

Listening and telling nursing stories would reassure us that we are not alone and give us opportunity to for our practice scope to grow and for us to contribute in information and support for our colleagues. Through the release of a story, we are able to explain ourselves and express ourselves, understand ourselves better and be heard by others. Storytelling is a process of learning and becoming. The conclusion to the thesis in Chapter 8 brings together this study in terms of from where the study originated, on which assumptions it rode, how it happened, what it found and recommendations for 'where to' from here.

Chapter 8: Conclusion

8.1 Ending – *'knowing' the practice*

This study exposes the complex realities of nursing unresponsive patients' pain in ICU through a dialectic approach of explanation and expression held together within a distinctive narrative methodology. The journey from my internal disquiet in response to the perceived 'guess' of pain care for unresponsive ICU patients to this presentation of my contribution towards nursing knowledge involved much fascination and many challenges. The major contributions of this thesis are the complex findings around pain, the innovative use of narrative methodology and the translation of sophisticated research processes into language accessible to clinicians. Looking for a simple answer of how to best ascertain pain cues led me to a multifaceted complexity involving nurses 'seeing', 'thinking', 'feeling', 'doing', 'listening' and 'speaking'. Sifting through the divergent complex narrative approaches brought me to an appreciation of the value of expressive forms that together with explanatory forms synthesise to a simple conception of 'voice'.

I set out to look at a nursing situation that I personally found challenging. I wanted to be able to elucidate what was happening in this situation for us as nurses and hopefully find things that would be helpful in seeing the situation more clearly. However, I could not find lists, causal relationships or clearly delineated options to provide to nurses who care for pain in unresponsive patients in order for their job to be made easier. In this study, when we considered providing comfort or treating pain in unresponsive patients, we were confronted with a nursing situation that presented challenges to our assessment and management. This problem situation was a focus for us to talk about nursing as the activity in which we engage during our time at work. Nursing activity is complex.

For structural clarity, the thesis has been presented in traditional chapters, however, within the nursing situation, such order does not exist, in fact, the ideas covered intertwine and may not even impact on our conscious awareness. It is only when we sit down to talk that we can articulate what happens, and only when I pour over transcripts and published literature that I can see some sense of interconnectedness. Readers will draw on their own person to relate to what is presented here.

Complexity is produced when many inter-related factors impact on what actually happens in the nurse-patient encounter. The model of knowledge we adhere to determines how we 'see' the patient; as parts with different needs or as a complete identity with illness impacting on the whole person. What we have formally learnt and what we continue to learn as we work and live impact on how we respond now. The way in which we approach our job; our commitment based on our individual selves and the individual patients, has a lot to do with the quality of the process of our nursing. Often the outcome is unknown. When what we can see and what we are able to do are out of alignment we end up dealing with frustration. Sometimes we cannot 'see' and other times we can 'see' but cannot 'do' because of the impediments of others' rules. How we have been socialised to relate to other health professionals, and how they relate to us, often interferes with our ideals. The institution and the unit place demands on us and create a context in which this situation takes place. We have restricted continuing time with individual patients based on the change of nurse-to-patient allocation each shift, thus we are impeded in our use of intuition in assessment and connection in patients' pain management. We may prefer this distancing from patients in an effort to cope with the trauma and disruption we 'see'.

8.1.1 About the contribution of the thesis

The significant contributions of the thesis are contained in eight areas:

1. The exposure of the complex realities around nursing unresponsive patients' pain in ICU.
2. The synthesis of the expressive and explanatory dialectic into 'voice'.
3. The creation of an original eclectic narrative methodology that dealt with real practice.
4. The exposure of the complex realities of the research process.
5. The exposure of the complex interplay of life on the research process.
6. The entering into the academic dialogue in an accessible way for clinical nurses.
7. The conceptualisation of the dialectical narrative situatedness schema.
8. The plan of implementation of the dialectical narrative situatedness approach to address nursing practice development.

8.1.1.1 The exposure of the complex realities around nursing unresponsive patients' pain in ICU

This study contributes to the understanding of complexity in nursing by investigating nurses' viewpoint of our work around pain as it occurred within the context of our ICU and toward the silent characters of unresponsive patients whose experiences were not available to us. The information came from nurses as storytellers and is autobiographical in that the tellers were telling about themselves in relation to others and in the context in which they found themselves. Nurses 'see', 'think', 'feel', 'do', 'listen' and 'speak'.

There are not many cues available for nurses to 'see' and these can be confused by physical causes other than pain, thus nurses make assumptions. The paradox of attributing pain to restlessness lay in the possibility of calm patients suffering pain. The paradox of assuming pain from nociception lay in nurses' requirement to inflict pain. The paradox of nurses imagining themselves in patients' place lays in the need for a healthy distance for nurses' psychological health and so some may focus on the priority of recovery. The paradox of relying on input from patients' relatives to help see indicators of pain lay in needy relatives distracting our attention away from patients. Adding to the complexity was our attempt to see where patients were headed in terms of the goal of care.

Nurses cannot know for sure what pain unresponsive patients in ICU are experiencing regardless of our level of learning or experience but we expect that we should be certain of our knowledge to ensure the provision of a consistent quality level of care. Being able to exert control over much of ICU nursing practice led some of us to seek certainty in the pain area in terms of dreaming of objective pain measurement devices not yet invented or placing ourselves under others' instruction such as guidelines or doctors. The knowledge that we drew on to help us manage pain whilst uncertain came from reflecting on our personal experience, our nursing experience of previous patients, hearing reports of patients' memories of their ICU experience, watching role models and absorbing theory. This complex knowledge comprised elements of the knowledge categories of 'case', 'patient' and 'person'. Accessing research did not figure prominently in our acquiring of knowledge about pain. Instead, we valued 'knowing the patient', conceding that this is made easier through continuity of care. We relied on our intuition when uncertain. Telling the story of where our knowledge has come from, what we have learnt and the complexity of what we now know would help us to be aware of the growth of our knowledge and would be a valuable contribution to

the body of nursing knowledge. Nurses' decision making involves drawing on the complexity of our knowledge and sharing our thoughts in our collaboration with doctors or in order to advocate for patients. Locating nursing knowledge within story elements allows for a more balanced understanding.

Working with pain when patient's experience is uncertain leaves nurses feeling frustrated and challenged by the difficulty, inadequate and stressed when being watched, and anguished by the possibility of patient suffering. While some nurses handle the complexity and accept a quantity of pain as necessary in ICU patients, other nurses employ strategies to cope with uncertainty. Directing effort towards fulfilling the nursing mandates of providing comfort and ensuring justice in patient care allows nurses to attach their significance to professional roles. Alternatively, nurses may choose their worth to be associated with the medical priority of cure. Telling the story of the professional nursing mandates that we are expected to carry out or the alignment with the medical model would help us to be aware of our growth into the role we have chosen and would be a valuable contribution to the nursing dialogue. Seeking closeness and connection with patients and relatives gives nurses opportunities to locate more information in order to become more certain, however over-involvement with patients can be psychologically harmful to nurses. A dialogue on the nursing story of being connected would add more depth to the complexity of what it is to be a nurse.

Nurses employed various options intended to treat pain and ensure comfort. The most trusted choice was morphine as the intravenous narcotic analgesic, usually together with midazolam as the sedative. Pharmacological options were intricately tied to working together with doctors in terms of prescription and withholding of drugs. Nurses relied on the amnesic quality of midazolam to reassure themselves that potential harm to patients from pain could be ameliorated. Within using drugs for pain care lay the paradox of administering analgesia but causing nausea or constipation. Nurses using touch for pain relief included positioning patients comfortably, moving them regularly, cleaning them and some informal types of massage but the paradox lay in nurses administering painful touch for procedures and neurological assessment. Nurses' talk that was intended to allay anxiety and give preparatory information before procedures was marked by minimising talk for the sake of not frightening patients but the paradox lay in nurses actually believing the minimising of pain caused by procedures. Nurses promoted sleep but disturbed patients in order to complete their work. Alternative pain therapies such as aromatherapy and music with imagery were dreamed of but not able to be attempted because of the restrictive nature of the unit environment.

When faced with uncertainty nurses may take the option of relying on other’s eyes to see, letting others tell them what to think, feeling the tension between expectations of certainty and the reality of uncertainty and follow a script on what to do. This study encourages nurses to see with their own eyes, value their own knowledge, feel part of a supportive group, do what is at hand, listen critically and speak confidently.

8.1.1.2 The synthesis of the expressive and explanatory dialectic into ‘voice’

Explanation and expression are complimentary ways to come to new understandings. Attaining new knowledge via the path of explanation involves analysis, classification, conceptualisation and theory-building whereas the path of expression lets meaning emerge through active involvement in dynamic sensing. Words were the vehicle of expression in this thesis. Realising nursing research’s imbalanced emphasis on explanatory research provided an opening for expression, and an appreciation of the reality of both explanation and expression being present in bedside nursing, led me to believe it would be expedient to use both paths in my research study. The contribution of this thesis is that it gains a complex understanding because it lives in the middle between the two paths. The ‘voice’ with which the thesis speaks is a synthesis of both explanatory and expressive word forms mainly relying on concepts from ‘story’.

8.1.1.3 The creation of an original eclectic narrative methodology that dealt with real practice

This thesis takes advantage of a vehicle of communication that is commonly used by people everywhere and especially within nursing in the form of storytelling. The original methodological contribution lay in a unique blend of narrative concepts that together uncover layers of meaning. From the initial analysis of structural and linguistic devices that storytellers use to bring home the point they want to convey to the audience, to the responsive expressive dialogue that deepened insights through dialectical sharing resulted in a synthesis of ‘our story’. My involvement in the study as participant-researcher added the authenticity of building on shared knowledge and experience. Significant gems along the way were a visual metaphor, a co-created collective story and a transcript collage poem.

My metaphorical response, evoked during transcript analysis, provided the visual comparison with ‘darkness’ that gave insights leading to appreciation of the areas of tension in which we worked. The co-created collective story described nurses’ ‘seeing’, ‘thinking’, ‘feeling’ and ‘doing’ and explained relationships, influences and outcomes.

Nurses may choose to use the collective story as an avenue for improvement through the provision of a collective consciousness between similarly situated individuals who may not have previously known how their colleagues felt, experienced, coped and practiced in this situation. The poem brings home the latent emotion of nurses responding to the uncertainty of possible pain.

If being human and especially nurses means we use stories to explain and express ourselves, and voicing through stories helps us in 'knowing' and 'being', then gathering information in the form of stories in research and then presenting findings in story forms would be an entirely appropriate way to add to our dialogue on the topic under scrutiny.

8.1.1.4 The exposure of the complex realities of the research process

The contribution of transparency in the processes of finding the 'best fit' methodology, choosing the suitable underpinning narrative works, and the comprehensive audit trail of method allows others to determine the trustworthiness of this research. My openness in portraying where the energy was spent and reasons why I pursued a 'practice friendly' methodology, may promote clinical nurses to value this work and have confidence to undertake their own investigation of topics pertinent to them. Laying down the meandering path debunks the myth of a clear-cut research journey and thus provides awareness to potential researchers.

8.1.1.5 The exposure of the complex interplay of life on the research process

A consciousness of the consequences of my use of 'self' in the process of this study not only contributed to the knowledge formed but also had implications for the time spent. Being an unfunded sole investigator involved in many other personal and nursing roles, the candid revealing of the impact of my life events causing delay on the research process makes public the situatedness of this thesis. Although time has been a contingency, the acknowledgment within the thesis of interruption is my contribution to the dialogue on research process in terms of ramifications on what knowledge is deemed acceptable.

8.1.1.6 The entering into the academic dialogue in an accessible way for clinical nurses

My contribution of being an advocate for clinical nurses is through finding out the clinical practice of pain care in unresponsive ICU patients and passing on the wisdom to other clinicians by means of 'story' as the avenue that is familiar to nurses. The advocacy role comes via my clinical standing as a member of the group of ICU nurses

and mirrors the reflective nature of storytelling. The findings of this study contribute to the dialogue within the nursing community by addressing a difficult area of clinical practice using an innovative method of research. I have contributed to this dialogue through the detailed account of complicated methodology presented in an accessible way for clinicians who would not normally engage with the world of academia. We, as clinical, research and academic nurses, need to continue to dialogue with each other over clinical problems, research methods, and research findings in order to continue to develop nursing practice.

8.1.1.7 The conceptualisation of the dialectical narrative situatedness schema

The contribution of illustrating the dialectic tensions that are apparent in the thesis as a visual diagram [see Figure 6.1.1] makes the dichotomies and alignments apparent. This diagrammatical simplification of the position and linkage of concepts facilitates comprehension of their complex interrelatedness. By visually aligning dialectic concepts, meaning emerges from the synergistic effect. The contribution of ‘seeing’ the story-world of nurses as depicted in the schema ameliorates the absence of a way to ‘see’ the pain-world of patients.

8.1.1.8 The plan of implementation of the dialectical narrative situatedness approach to address nursing practice development

As a contribution towards the way forward from this thesis, I have suggested implementing a physical and temporal space for nurses to systematically dialogue through the schema as a nursing practice development option. Critiquing the source and the content of nurse’s knowledge, the authority over and the expectations on nurses’ role, sharing nurses’ inner wisdom and feelings about a particular topic represents a comprehensive and balanced approach to dealing with the complexity that is nursing. Keeping the schema simple would allow nurses to integrate a critical stance to listening and be confident in telling the story of their everyday practice.

8.1.2 About the significant outcomes of the study**8.1.2.1 Outcomes for nurses**

- a. There is still no answer to my quest for a definitive measure of pain when patients cannot tell.
- b. Nurses whose experiences resonate with the collective story will not feel alone in the difficulty of working within uncertainty.

- c. Value is placed on expressive sharing through recognition of the importance of our easy and natural telling of stories in informal settings and adding the opportunity for forms of expression in more formal settings.
- d. Responsibility to grow through critically listening to external ‘voices’.
- e. Responsibility to contribute through ‘voicing’ with directness and assurance.
- f. Implication for the mini-narrative of handover – give credence to the value of face-to-face dialogue rather than written or taped information [connection, opportunity to clarify or challenge].
- g. Implications for the mini-narrative of doctors’ rounds – consciously choose to acquiesce or speak out and thus value-add to the information on which decisions will be made.
- h. Implications for nursing curriculum – value both explanatory and expressive content and make adjustments to be more balanced.

8.1.2.2 Outcomes for patients and relatives

- a. The ability to understand and handle complexity allows nurses the freedom to provide quality care.
- b. Relatives will be valued for their source of patient knowledge.
- c. Promote more expressive content to complement the existing explanatory content included in information for patients and relatives.
- d. The realisation that although nurses may be experts, they are also complex and human, which allows for a more authentic interaction between nurses and patients’ relatives.

8.1.2.3 Outcomes for doctors

- a. Receive a more confident and clearer presentation of nursing information.
- b. Nurses contribution adds to width/depth of creative elements to doctors’ analytical approach on which to make decision of patient care.

8.1.2.4 Outcomes for the university

- a. Kudos from supporting the formation of new knowledge.
- b. Another thesis in the library.
- c. Another PhD nursing graduate in the statistics.
- d. A sigh of relief!

My real interest in undertaking this study was to find out about all the elements that make up what it is for us to nurse unresponsive patients pain in ICU - about the patient, about us as nurses, about the environment of ICU, about why it is hard and what may help to improve the situation for us and for the patients. Once explicated and written, nurses in this situation reading this study, should be encouraged by the fact that other nurses face the same difficulties, and may comprehend that they have the resources within themselves to manage well.

8.1.3 An expressive conclusion

I end with a poem reflecting on how I felt and what I thought at the end of the thesis journey. Here is my expressive voice of pride and hope yet with tinges of doubt. It is a poem of letting go of the process and delivering the product.

Knowledge
Understanding
Nutting it out

Concentration
Time spent
Brain stretch

Pulling apart
Putting together
Words
Sentences
Paragraphs
Chapters
The whole

I know understanding will help
The nurses have asked for this knowledge
But I feel dumb

I feel ashamed that I have been doing this for so long
I feel the tension between living my life and study
I am jealous of others' support
But I feel proud that I lived out my determination to finish

I have these gems
I'm attaching to a silver chain
The chain has to be the right design and strong enough to carry them
They have to be orderly arranged to bring out their colours the best way
The gems need to be polished
The clasp needs to be secure
Its nearly there
One day I'll wear it

Being a clinician
Being an academic
Being both
Neither is done well

Clinicians think the chain is ugly
Academics think the gems are dull
Will I pass having put it together?

- Nerilee -

Chapter 9: Postscript

9.1 My poem in two voices - *answering my question*

Below is a poem showing my voice as a clinician. I was imagining myself at work as I was reflecting on the findings of this thesis in order to answer a colleague's curiosity.

Nerilee (Registered ICU nurse)

"You'll never guess what just happened..."

Its the prelude to wisdom

Acting out our role

Not knowing the script

Pretending in the spotlight

Quaking in the shadows

Listen to the tea room chat

There's a lot that's not in books

Take it in

Then let it out

Below is a poem showing my voice as an academic student. I was imagining myself in a seminar as I was reflecting on the findings of this thesis in order to answer a query from the audience.

Nerilee (PhD candidate)

We live a story, we tell it.

We tell a story, we live it.

Pain is what the patient says it is.

But when patients can't say,

Pain is what the nurse says it is for the patient.

When our story is heard we begin to have choice.

We can make our story happen.

Appendix A

Consent form - *gaining the authorisation*

The required paperwork to show informed consent of the participants as referred to in sub-section 4.1.4.3 of the thesis.

I _____ agree to participate in the research project Stories of nursing: managing physical comfort and pain in critically ill patients who are incapable of purposive actions being conducted by Nerilee Baker, 3 Abbotford Street, Kensington, 2033, ph (02)6626212(H) or (02)3612036(W), of the University of Technology, Sydney, for the purpose of obtaining a Master of Nursing by Research¹.

I understand that the purpose of the study is to descriptively document narratives of intensive care nurses as they manage physical comfort and pain in patients who are unconscious or unable to communicate.

I understand that my participation in this research will involve an interview of approximately one hour in length, occurring at a mutually suitable time and place, during which I will be asked to tell my story as an intensive care nurse dealing with physical comfort and pain in patients who are incapable of purposive actions. The interview will be recorded on audio cassette then later transcribed. A copy of my transcript may be obtained from Nerilee Baker on request. Any identifiers will be removed from this material and it will be stored securely. My confidentiality will be maintained.

I am aware that I am at liberty to contact Nerilee Baker or either of her supervisors, Jackie Crisp (Ph: 3305050) or Sue Nagy (Ph: 3305121) if I have any concerns about the research. I also understand that I am free to withdraw my participation from this project at any time I wish without giving a reason.

I agree that Nerilee Baker has answered my questions fully and clearly.

I agree that the research data gathered from this project will not be published in a form that identifies me in any way.

Signed by

___/___/___

Witnessed by

___/___/___

Note:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research you may contact the Ethics Committee through the Research Ethics Officer, Ms Susanna Davis (Ph:3301279). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

¹ The project commenced as a master's research and changed to doctoral work in 1998

Appendix B**Bibliography related to narrative analysis - *laying the foundation***

This is my beginning list of narrative analysis literature referred to in section 3.2 of the thesis. This is where I commenced when forming my particular way of narrative thinking for methodology, method and analysis.

- Arndt, MJ. (1992). Caring as everydayness. Journal of Holistic Nursing, 10(4), 285-293.
- Bailey, PH. (1996). Assuring quality in narrative analysis. Western Journal of Nursing Research, 18(2), 186-194.
- Banks, A. (1992). Once upon a time: interpretation in literature and medicine. Literature and Medicine, 1(1), 24-28.
- Bar-On, D. (1992). A testimony on the moment before the (possible) occurrence of a massacre: On possible contradictions between the ability to adjust which means mental health and the maintaining of human moral values. Journal of Traumatic Stress, 5(2), 289-301.
- Barthes, Roland & Duisit, Lionel (1975). An introduction to the structural analysis of the narrative. New Literary History, 6(2), On Narrative and Narratives, 237-272
- Barthes, Roland (1977): Image, Music, Text. (Essays selected and translated by Stephen Heath) Hill and Wang, New York.
- Beach, Wayne A; Japp, Phyllis (1981): Storifying as time-travelling: The knowledgeable use of temporally structured discourse. Chap. 40. In: A philosophy of communication: Exploration for a systematic model. (Ed: Kelly, John C) Centre for the study of communications and culture, London, 867-888.
- Beiner, R (Ed.) (1982): Hannah Arendt: Lectures on Kant's political philosophy. Chicago University Press, Chicago.
- Benner, P (1991): The role of experience, narrative, and community in skilled ethical comportment. Adv Nurs Sci 14(2), 1-21.
- Borkan, Jeffery M; Quirk, Mark; Sullivan, Michael (1991): Finding meaning after the fall: Injury narratives from elderly hip fracture patients. Soc. Sci. Med. 33(8), 947-957.
- Borkan, Jeffrey; Shvartzman, Pesach; Reis, Shmuel; Morris, Avigail, G (1993): Stories from the sealed rooms: Patient interviews during the Gulf War. Family Practice 10(2), 188-192.
- Boykin, Anne; Schoenhofer, Savina O (1991): Story as link between nursing practice, ontology, epistemology. IMAGE J Nurs Sch 23(4), 245-248.
- Brown, Lyn, M; Tappan, Mark B; Gilligan, Carol; Miller, Barbara, A; Argyris, Dianne E (1989): Reading for self and moral voice: A method for interpreting narratives of real-life moral conflict and choice. Chap. 5. In: Entering the circle: Hermeneutic investigation in psychology. (Eds: Packer, Martin J; Addison, Richard B) State University of New York Press, Albany, 141-164.
- Bruner, Edward M (1986): Ethnography as Narrative. Chap. 6. In: The Anthropology of Experience. (Eds: Turner, Victor W; Bruner, Edward M) University of Illinois Press, Urbana, 139-155.
- Churchill, Larry R; Churchill, Sandra W (1992): Storytelling in medical arenas: the art of self determination. Literature and Medicine 1(1), 74-81.
- Cohler, Bertram J (1994): The human sciences, the life story, and clinical research. Chap. 13. In: Qualitative Research in Social Work. (Eds: Sherman, Edmund; Reid, William J) Columbia University Press, New York, 163-174.
- Connelly, F Michael; Clandinin, D Jean (1990): Stories of experience and narrative inquiry. Educational Researcher 19(5, June-July), 2-14.
- Denzin, Norman K (1987): The alcoholic self. Sage, Newbury Park, CA. 231 pages.

- Dzurec, Laura Cox (1991): Prefacing knowledge development in nursing: telling stories. Can J Nurs Res 23(4), 35-42.
- Early, Evelyn A (1982): The logic of wellbeing - Therapeutic narratives in Cairo, Egypt. Soc. Sci. Med. 16, 1491-1497.
- Ferraro, Kathleen J; Johnson, John M (1983): How women experience battering: the process of victimization. Social Problems 30(3), 325-339.
- Forster, EM (1927): Aspects of the Novel. Edward Arnold & Co., London. 224 pages.
- Gee, JP; Grosjean, Francois (1984): Empirical evidence for narrative structure. Cognitive Science 8, 59-85.
- Gee, James Paul (1985): The narrativization of experience in the oral style. Journal of Education 167(1), 9-35.
- Gee, James Paul (1986): Units in the production of narrative discourse. Discourse Processes 9, 391-422.
- Gee, James Paul (1988): Dracula, the vampire Lestat, and TESOL. TESOL Quarterly 22(2), 201-225.
- Gee, James Paul (1989): "Literariness", Formalism, and Sense Making: The line and stanza structure of human thought. Journal of Education 171(1), 61-74.
- Gee, James Paul (1989): The narrativization of experience in the oral style. Journal of Education 171(1), 75-96.
- Gee, James Paul (1989): Orality and Literacy: From the savage mind to ways with words. Journal of Education 171(1), 39-60.
- Gee, James Paul (1989): Two style of narrative construction and their linguistic and educational implications. Journal of Education 171(1), 97-115.
- Gee, James Paul; Kegl, Judy Anne (1983): Narrative/story structure, pausing, and American sign language. Discourse Processes 6, 243-257.
- Gergen, Kenneth J; Gergen, Mary M (1986): Narrative form and the construction of psychological science. Chap. 2. In: Narrative psychology: The storied nature of human conduct. (Ed: Sarbin, Theodore R) Praeger, New York, 22-44.
- Good, Byron J; Good, Mary-Jo Del Vecchio (1994): In the subjunctive mode: Epilepsy narratives in Turkey. Soc. Sci. Med. 38(6), 835-842.
- Gregory, David; Longman, Alice (1992): Mothers' suffering: Sons who die of AIDS. Qual. Health Res. 2(3), 334-357.
- Hall, Joanne M; Stevens, Patricia E; Meleis, Afaf Ibrahim (1992): Developing the construct of role integration: A narrative analysis of women clerical workers' daily lives. Res Nurs Health 15, 447-457.
- Hunt, Linda M (1994): Practicing oncology in provincial Mexico: A narrative analysis. Soc. Sci. Med. 38(6), 843-853.
- Hymes, Dell (1982): Narrative form as a "grammar" of experience: Native Americans and a glimpse of English. Journal of Education 164, 121-142.
- Jefferson, Gail (1978): Sequential aspects of storytelling in conversation. Chap. 9. In: Studies in the organization of conversational interaction. (Ed: Schenkein, J) Academic Press, New York, 219-248.
- Kemp, T Peter (1988): Toward a narrative ethics: a bridge between ethics and the narrative reflections of Ricoeur. Philosophy and Social Criticism 14, 179-201.
- Labov, William (1982): Speech action and reactions in personal narrative. In: Analysing Discourse: Text and Talk. (Georgetown University Round Table on Languages and Linguistics 1981) (Ed: Tannen, Deborah) Georgetown University Press, Washington D.C., 219-247.
- Labov, William; Waletzky, Joshua (1967): Narrative analysis: Oral versions of personal experience. In: Essays on the verbal and visual arts: Proceedings of the 1966 Annual Spring Meeting of the American Ethnological Society. (Ed: Helms, June) University of Washington Press, Seattle, 12-44.

- Laird, Joan (1994): "Thick description" revisited: Family therapist as anthropologist-constructivist. Chap. 14. In: *Qualitative Research in Social Work*. (Eds: Sherman, Edmund; Reid, William J) Columbia University Press, New York, 175-189.
- Langellier, Kristin M (1989): Personal Narrative: Perspectives on theory and research. *Text and Performance Quarterly* 9(4), 243-276.
- Lehnert, Wendy G (1981): Plot units and narrative summarization. *Cognitive Science* 4, 293-331.
- Linde, Charlotte (1986): Private stories in public discourse. *Poetics* 15, 183-202.
- Maines, D (1989): The storied nature of diabetic self-help groups. Paper presented to the Gregory Stone Symbolic Interaction Symposium, Arizona State University, Tempe, Arizona.
- Mandler, Jean Matter (1984): *Stories, Scripts, and Scenes: Aspects of Schema Theory*. Lawrence Erlbaum Associates, Hillsdale, New Jersey. 132 pages.
- Martin, Ruth R (1994): Life forces of African-American elderly illustrated the oral history narratives. Chap. 15. In: *Qualitative Research in Social Work*. (Eds: Sherman, Edmund; Reid, William J) Columbia University Press, New York, 190-199.
- Mishler, Elliot G (1986): The analysis of interview-narratives. Chap. 12. In: *Narrative psychology - the storied nature of human conduct*. (Ed: Sarbin, Theodore R) Praeger, New York, 233-253.
- Mishler, Elliot G (1990): Validation in inquiry-guided research: The role of exemplars in narrative studies. *Harvard Educational Review* 60(4), 415-442.
- Mumby, Dennis K (1987): The political function of narrative in organizations. *Communication Monographs* 54(June), 113-127.
- Nye, Catherine H (1994): Narrative interaction and the development of client autonomy in clinical practice. *Clinical Social Work Journal* 22(1), 43-57.
- Parker, Randy Spreen (1990): Nurses' stories: The search for a relational ethic of care. *Adv Nurs Sci* 13(1), 31-40.
- Polanyi, Livia (1985): Conversational Storytelling. Chap. 13. In: *Discourse and Dialogue*. Vol. 3. (Ed: van Dijk, Teun A) (Handbook of Discourse Analysis.) Academic Press, London, 183-201.
- Polkinghorne, Donald E (1988): *Narrative knowing and the human sciences*. State University of New York Press, Albany.
- Reilly, Fay E (1993): Experiences of family among homeless individuals. Iss. *Mental Health Nurs.* 14, 309-321.
- Ricoeur, Paul (1984): The model of text: meaningful action considered as text. *Social Research* 51, 185-218.
- Richardson, Laurel (1988): The collective story: Postmodernism and the writing of sociology. *Sociological Focus* 21(3), 199-208.
- Richardson, Laurel (1990): Narrative and sociology. *Journal of Contemporary Ethnography* 19(1, April), 116-135.
- Riessman, Catherine Kohler (1993): *Narrative Analysis*. Vol. 30. (Series Ed: Hunter, Judith L. *Qualitative Research Methods*.) Sage, Newbury Park. 79 pages.
- Robinson, Carole A (1993): Managing life with a chronic condition: The story of normalization. *Qual. Health Res.* 3(1), 6-28.
- Rosaldo, Renato (1986): Ilongot Hunting as Story and Experience. Chap. 5. In: *The Anthropology of Experience*. (Eds: Turner, Victor W; Bruner, Edward M) University of Illinois Press, Urbana, 97-138.
- Sandelowski, Margaret (1991): Telling stories: Narrative approaches in qualitative research. *IMAGE J Nurs Sch* 23(3), 161-166.
- Sarbin, Theodore R (1986): The narrative as a root metaphor for psychology. Chap. 1. In: *Narrative Psychology: The Storied Nature of Human Conduct*. (Ed: Sarbin, Theodore R) Praeger, New York, 3-21.

- Sarbin, Theodore R (1989): Emotions as narrative emplotments. Chap. 7. In: *Entering the circle: Hermeneutic investigation in psychology*. (Eds: Packer, Martin J; Addison, Richard B) State University of New York Press, Albany, 185-201.
- Scholes, Robert; Kellogg, Robert (1966): *The Nature of Narrative*. Oxford University Press, New York. 326 pages.
- Soderberg, Anna; Norberg, Astrid (1993): Intensive care: situations of ethical difficulty. J Adv Nurs 18, 2008-2014.
- Stempel, Wolf-Dieter (1986): Everyday narrative as a prototype. Poetics 15, 203-216.
- Stevens, Patricia E (1993): Marginalized women's access to health care: A feminist narrative analysis. Adv Nurs Sci 16(2), 39-56.
- Strickland, Lee (1994): Autobiographical interviewing and narrative analysis: An approach to psychosocial assessment. Clinical Social Work Journal 22(1), 27-41.
- Tannen, Deborah (Ed.) (1982): *Analysing Discourse: Text and Talk*. (Georgetown University Round Table on Languages and Linguistics 1981) Georgetown University Press, Washington D.C. 382 pages.
- Tannen, Deborah; Saville-Troike, Muriel (Eds.) (1985): *Perspectives on Silence*. Ablex, Norwood. 251 pages.
- Tappan, Mark B (1989): Stories lived and stories told: The narrative structure of late adolescent moral development. Human Development 32, 300-315.
- Tappan, Mark B (1990): Hermeneutics and moral development: Interpreting narrative representations of moral experience. Developmental Review 10, 239-265.
- Tobin, Sheldon S (1994): Commentary: Narrative in Clinical Research. Chap. 16. In: *Qualitative Research in Social Work*. (Eds: Sherman, Edmund; Reid, William J) Columbia University Press, New York, 200-201.
- Twigg, Robert C (1994): The unknown soldiers of foster care: foster care as loss for the foster parents' own children. Smith College Studies in Social Work 64(3), 297-312.
- Uden, Goggi; Norberg, Astrid; Lindseth, Anders; Marhaug, Venke (1992): Ethical reasoning in nurses' and physicians' stories about care episodes. J Adv Nurs 17, 1028-1034.
- Vezeau, Toni M (1992): Use of narrative in human caring inquiry. Chap. 14. In: *The presence of caring*. (Ed: Gaut, DA) National League of Nursing, New York, 211-221.
- Viney, Linda L; Bousfield, Lynne (1991): Narrative analysis: A method of psychosocial research for AIDS-affected people. Soc. Sci. Med. 32(7), 757-765.
- Vitz, Paul C (1990): The use of stories in moral development: New psychological reasons for an old education method. Am. Psych. 45(6), 709-720.
- White, Hayden (1980): The value of narrativity in the representation of reality. Critical Inquiry 7(Autumn), 5-27.
- Winch, Christopher (1985): Cooper, Labov, Larry and Charles. Oxford Review of Education 11(2), 193-200.
- Young, Katharine (1984): Ontological puzzles about narrative. Poetics 13, 239-259.

Appendix C

Interview prompt - *forming the focus*

A schedule to remind me of the areas I wanted to cover during the interview discussion as detailed in sub-sections 4.1.2.1 and 4.1.5.1 of the thesis.

Telephone:

I'm doing some research in the unit for my masters¹. I'm looking at what it is like for nurses to work with critically ill patients when they aren't capable of purposive actions - like when they're unconscious or paralysed with drugs. I'm specifically looking at physical comfort and pain issues. The reason why I'm doing this research is because I personally found it complex and varying. So I would like to have your perspective on it. Would you be willing to talk to me and my tape recorder? I assure you that all you say will be held in confidence and that no one will know you participated in my research unless you tell them.

Arrange place and time and answer questions.

Interview:

Thankyou for agreeing to be involved in this research. Remember, if you wish, you may stop the interview at any time and ask me not to use anything that you have said and it won't be a problem.

The reason why I am doing this research is because I want to know more about comfort/pain management in ICU. I'm not looking for black and white answers, rather a variety of view points. My research is looking for diversity in nursing - we all do things a bit differently because of who we are and the different experiences we have encountered.

We both work together in the unit, but in the context of this interview its what you have to say that's important to me.

When you think about comfort/pain management, how do you deal with the unresponsive patient?

Can you give me an example?

Tell me about it?

What do you think about? What goes through your head? (mind, thoughts, consciousness)

How do you feel? (feelings, emotions)

What do you do? (actions)

What is your aim/goal? (purpose)

What should it be like? (values)

What things help or hinder you when you are in this situation?

How did you arrive at this position?

¹ The project commenced as a master's research and changed to doctoral work in 1998

Were there good or bad situations of comfort/pain management that influenced your present position?

Set it up as a discussion then get in there and discuss = consistent with the status of a colleague

My perspective:

**no literature with answers
difficult to assess ?what do non verbals mean
conflict with medical staff over orders/priority of pain management
clearance of analgesia - renal/liver failure
Admission
dying
paralysis without analgesia**

(why of human actions = story)

Attitude = their information is important
Language = they know what is going on best
Don't assess or judge their ability
Always acknowledge their expertise

If they assume knowledge - ask them to explain more for the sake of transcribing
(I can only work with what is said and written)

Is there anything else we should discuss before I leave?

Can you think of anything I have missed?

Thankyou for contributing to my research, it was worthwhile time spent.

1 **Appendix D**

2 **Transcription sample - *texting the sounds***

3 *A transcription excerpt to show my notation as described in sub-section 4.1.6 of the*
4 *thesis. This is an excerpt taken from within a transcribed conversation. All utterances*
5 *are preserved as transcribed. I have kept the line numbering as it appears in the actual*
6 *transcription.*

7 *[There is an intentional large space on this page before the transcribing begins as I*
8 *chose to show a sample that began on line 32]*

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32 *Ha'have you ever looked after anyone whose n'not responding at*
33 *all, you know, I guess in that sort of like long term stage, who*
34 *doesn't wriggle around or doesn't isn't rigid or, do you know?*
35 *Have you have you ever looked after someone like that's just*
36 *unresponsive?(to to pain relief?) To, like they're an*
37 *unresponsive patient but they might be on a morphine infusion at*

1 *one or two mls an hour or something. (Yeah) So do you just*
2 *leave it or (um) How do you tell with those sort of people that*
3 *(...)(Ah that that is, that's hard isn't it? Its um, its I mean,*
4 *yeah, its.. you fall into a..) 'cause you oh yeah (I see what you*
5 *mean).*
6
7 *Y'you, I mean, there are those people that sort of wriggle*
8 *around that aren't sort of, I mean yeah, (yeah) sort of really*
9 *purposeful in any way (yeah) but but there's sort of a degree*
10 *of agitation that you assume is associated with pain (Yeah)*
11 *and discomfort (yeah) but then I guess there are those that,*
12 *um, can't move at all. (yeah) Um, mm, that's ah, that's a very,*
13 *ah, its a feeling one I think its not a looking one, um, (and*
14 *you've got to go on your feelings) you've got to, you've got to*
15 *try and start to, um, look at, um, yes subjunc subjective*
16 *feelings, ah..*
17
18 *Mm, 'cause I guess I oh, personally I sometimes tend to see*
19 *the infusions just sort of creeping up or creeping down*
20 *depending on who's looking after them and (yeah) sometimes I*
21 *wonder why, (that's right yeah) what what do people go on?*
22
23 *Um but I mean, and you can see that, y'you can see it, you can*
24 *see someone come along, and if you ask someone's opinion*
25 *too, um, some people.. there can be a difference like three or*
26 *four, um, mls an hour which is (laugh) which is a fair bit, I*
27 *mean, that's a lot of.. I mean, when you consider it over say*
28 *(24 hours) I mean even two two mls over 24 hours I mean that*
29 *that's 48 mgs (Mm) of something, um, that that's a lot of of*
30 *relief, um. (yeah) Um so but that's subjective, (Yeah) um,*
31 *obviously that person either feels that, "No, he hasn't got any*
32 *pain." or "God, he must be in a lot of pain with that." (yeah)*
33 *Um.*
34
35 *I guess I wonder what that's based on, what (Yeah) is it just a*
36 *just a gut reaction or..*

1 Yeah, its I I think there is a gut feeling, (*Yeah*)ah, and
2 everyone'll say go with your gut gut yeah instincts, (*Yeah*)um,
3 because more than often y'you correct in those instincts.
4 (*Yeah, but its funny that that, like you say, that one person's*
5 *gut instinct is 3 or 4 mls out to another persons.*)Yeah, its
6 like doing a multi-choice. Its, um, (*laugh*)I I think if if you if you
7 had the one patient and s' got four people that were on that
8 afternoon, I I re l'd lay a bet that you could a range of say.. if
9 it was sitting there on say five and said, "Do you think he
10 needs more or do you think he needs less?" and if you put a
11 case down, the exact same case to each person, I think you
12 could go from say about, a low of about three, one person
13 saying, "No, I think you could start to wean it down a bit.",
14 (*Mm*)um, whereas a person may say, "No, keep it as it is,
15 that's fine." and another person saying "No, I I think l'd
16 increase it one or two just to see how it goes." Um, so (*yeah*)
17 ah, mm, (*Mm*)Then I think some people are sort of blazé about
18 it and they they go, "What the hell, he'll be right, he's
19 ventilated, he'll be fine." um, which which I guess, when you
20 think about it, is good and is bad, I mean, ah, I mean, people
21 think yeah, "Respiratory depression, OK that's the primary
22 (*Mm*)sort of side effect." Um, but there's nausea as well, I
23 mean, there's this person sitting there and can't move and
24 literally trying to wretch their guts up 'cause they've had it.. I
25 mean, we we don't (*Mm, we don't think*) I mean, when you
26 think about it we give morph and midazolam, how many times
27 on the ward, I mean, if if you've.. when you last worked in the
28 wards, or say down in a acute sort of a a ah, like um, cas or
29 somewhere, how many times have you given someone just 5
30 mgs of IV morph to quell a bit of pain, and they've gone, "I feel
31 sick now," and thrown their guts up. But we don't give any
32 maxalon or anything like that (...) regularly (*large aspirates*
33 *and you wonder why they've got large aspirates (laugh)*). I I
34 know, I mean, (*yeah*) perhaps, um, it would help to.. OK
35 there's side effects again from each of those drugs, like
36 maxalon, (*Mm*) but um, but it it may.. that could be one thing
37 that is enough to help that person through, (*Mm*) because,

- 1 OK its provided the pain relief, OK m' my broken leg's feeling
- 2 quite good now, but shit l'm feeling pretty crook , l mean,.....
- 3 (Int4,p12:32-p15:2)

Appendix E

Collective story in one episode - *creating one episode*

This is a later draft of the collective story using nurses' words within the Johnson and Mandler episodic folktale structure but with just one episode as detailed in sub-section 4.2.2.3 of the thesis. An outline for this later draft can be found in Appendix F. The nurses' quotes at the beginning of this version were changed to past tense to make them fit grammatically with my writing but this idea was abandoned due to the tediousness of both editing and reading the changed quotes.

What the nurses said looks like this

What I said looks like this

What I wrote looks like this

Location of the story; time, place and characters

Various nurses, doctors and other staff worked together for the benefit of critically ill patients in a major teaching hospital's intensive care unit. We, eleven of the nurses, told the following collective story of managing comfort and pain for critically ill patients who were not capable of purposive actions. These were *patients that I personally* [couldn't] *tell what's happening with them.* (4:2,4-5)

Beginning event; allocation

Every shift, nurses were allocated by the shift leader to take care of individual patients. We often cared for different patients each shift and worked a variety of days and nights.

Reaction caused goal; degree of connection with patient caused commitment given to providing comfort and alleviating pain

The individuality of nurses, both as humans and professionally, caused us to achieve different levels of connection with these patients. We reacted to these patients on a personal level depending on what we were able to glean of their personhood. As nurses, we reacted to their physical condition, relying on our experiences and knowledge to estimate what comfort or pain they might be experiencing. A closer connection, together with a belief that it was our job, motivated us to want to provide comfort and the relief of pain for these patients.

Reaction; degree of connection with patient

Nurses were supposed to care for all patients equally and our care involved providing comfort and alleviating pain, however, we had varying reasons for connecting with some patients more easily than others.

The patient seen as friend or foe

Aspects within some of these patients stood out to either help or hinder us in forming a caring relationship with them. If we imagined these patients to be like one of our loved ones, we felt like putting more effort into their care, whereas, if these patients directed abusive behaviour towards us, we felt less inclined to do other than what was necessary.

Robyne felt generally, you know, you like[d] all the patients, but if (sigh) I don't know, if it was like your mother in that bed, you'd be wanting to do absolutely everything for her. The level of care you'd give her would be much better than Joe Blow off the street (3:10,3-7) **Robyne told of an incident that happened to her** on night duty there was a guy once with HIV who ripped his cannulas out and was like spurting them at the ward staff and jumped out of bed and said, "I'm going to give this all to you." you know and swearing, and it [was] like well, you [didn't] have much empathy for someone like that really. And it [was] like, "Well, OK, go. I don't care, leave." You know, it [was] hard, and, I don't know, confused patients that [said] hurtful things, just [had] to like take it with a grain of salt. (3:10,8-17) **Leticia also felt** there [were] other patients, I'm speaking quite honestly, that you [didn't] have any great affection for and you just [did] the job and you may not [have thought] so deeply about how much pain they [had] (1:13,14-17) **But Bryce thought that each patient deserve[d]** the same degree of care (4:8,26-27).

We related to these patients as human to human. The more we could see of their humanity, the greater the possibility for connection. However, they did not respond to us, which we found was an obstacle and an opportunity.

Lack of cues from the patient hampered assessment but sometimes elicited closer nursing observation

We were not privy to the usual range of comfort and pain cues from these patients which made it difficult for us to assess their comfort or pain experience, but because these patients were unable to tell or indicate to us how they felt, some of us felt even more responsible for this type of patient.

The range of assessment indicators of the experience of comfort or pain available to nurses included, at best, listening to awake patients' verbal descriptions and at worst, observing and interpreting patients' behaviours. However, it was not possible for these patients to verbally communicate at all, just even by sign language or anything like that (7:1,22-24), and the range of behaviours exhibited by them were limited to non-purposeful movements beyond their control... like a bit of thrashing and something like that (4:1,30-31,36-37), or no response, **Patrick's patient couldn't** even grimace to sort of say that they [were] in pain and stuff like that (5:2,3-5) **Patrick thought** you [had] none of your normal indicators that somebody [was] in pain that you just, I mean, it sort of seem[ed] sort of that it slip[ped] into the background a little bit (5:7,2-4) it [was] sort of easy to slip into forgetting that there [was] somebody there (5:7,37-8,1) **Rhea's patient** had a huge abdominal dressing and I know I personally did that dressing and got no reaction out of him and I felt that he wasn't experiencing any pain because I could, there was nothing there was no physical signs (8:12,25-30)

The lack of response from these patients resulted from their pathophysiology or drug induced sedation or paralysis. Beth noted that types of these patients included head injuries... or patients that have been sedated heavily for some other reason.(7:1,34-36) **Toni's patient** was ventilated and paralysed and sedated and things (6:1,24-25)

Because these patients were vulnerable, we felt responsible for establishing a connection with them and their experiences. Leticia acknowledged that this patient [couldn't] tell you they [were] in pain so you [were] the one that need[ed] to be able to look at them (1:5,15-16) **Taylor remembered contrasting patients on the wards**, in ITU... people [didn't] complain of being in pain... it [was] up to us to assess them and if they [were] getting adequate pain relief ... I find that it [was] a lot more nurse initiated in ITU for the patient than other wards 'cause the patient on a

communicating ward would tell you that they're in pain or they [would] scream or they [wouldn't] move if they [were] in traction or stuff (9:8,29-32,9,2-7)

We found it difficult to clearly see what comfort or pain these patients were experiencing. I thought this is really difficult, I don't know what's going on for this patient, (5:12,26-27) **Patrick agreed that it was just so difficult to assess** I think (5:2,22) like "Oh, look, I'm just doing your dressing here," and... your abdomen is right open, you know, "Is that painful at all?" and "You're not just giving me any..." (5:7,27-30) **Leticia stated that assessment was difficult to do because you [were] using your ideas and the way you [thought] that person [felt] and putting them onto them and behaving accordingly (1:1,30-33) Bryce also felt when a person [wasn't] capable of their own actions, you depend[ed] very much on other people, including yourself, to try and interpret how they're feeling (4:2,28-31) I guess there's never going to be a way whereby we can truly assess it (4:7,15-16)**

It was hard for us to see clear picture of our patients because they could only provide us with physiological and behavioural information about their comfort or pain which we then had to interpret. So we looked to other sources for insights into these patients' experiences.

The relatives helped reveal these patients as people

Relatives were a great source of insight into the personhood of these patients. Through their descriptions, visiting behaviours and sometimes direct questions, we were able to see the whole person, and focus on their comfort and pain.

Relatives helped us to see the person. Bryce often [found] the family [told him] what a person [was] like (4:3,11) ...spouses [were] the closest, I mean if they [were] sleeping with them every night in a double bed... I mean especially an elderly person, say for the last thirty years, then, you [had] someone who [knew] this person back to front. (4:3,30-34) I think you start[ed] to look at family and how perhaps that person [was] responding to that (4:7,4-5) **Taylor found the relatives... might [have thought] they're in pain and they probably [knew] the person better than we [did] anyway and might, I don't know, sometimes by talking to the relatives you [could] pick up, you know, little things (9:3,4-10)**

Relatives helped us to focus on comfort. I thought *...when the patient's relatives [were] going to come in, you also look [ed] at the patient in a different light, I [did] anyway... look[ed] at them through what you think the relatives [were] going to see.* (5:20,26-30) **Contact with relatives caused Patrick to reconsider his patient's comfort and pain, he said, when relatives [rang] to see how the patient [was] doing... especially with the ones that [were] like really unconscious I think we always [made] a point of saying, "Well, they're comfortable and they're pain free," ...if nothing else, it still [made] you think, you know, "Is he really, he or she really pain free or not?", you know, sort of. At least, you sort of, it [came] back into your brain and sort of, and [made] you sort of look at it again, and see whether they [were] or not.** (5:20,13-17,21-25) **Sometimes relatives asked us directly about comfort. Taylor's patient, a person who couldn't communicate.. (9:4,17) it was a head injury, and... all his vitals were OK, he was just laying there. He looked comfortable but the relatives kept asking me, "Are you sure they're not in pain?" And they weren't on any infusions or anything and I wasn't certain that they weren't in pain (9:4,24-29)**

We made the patients comfortable for the relatives to see. Patrick felt that maybe we [were] sort of delaying the time between the patient arriving and the actually letting the relatives in for the

relative's sake, to, you know, have the patient nice and comfortable and pain free and clean sheet and I think that's another one of those things where we [were] just tak[ing] a guess, because I think sometimes that [was] good for them and other times people just prefer[ed] to come in and no matter what... nothing [brought] it home better than having [had] to sit in a waiting room yourself in another hospital in intensive care (5:20,31-21,17)

Relatives helped improve our vision of these patients as people, with the possibility of being comfortable or in pain. But at times the relatives also needed our care.

Caring for the relatives' needs hindered connection with these patients

The relatives also needed to connect to their loved ones in this unusual and threatening situation. Often they turned to us to provide information about pathophysiology and an idea of expected outcomes. At times we felt the relatives were assessing our adequacy. Caring for the needs of relatives sometimes diverted our time and focus away from these patients.

Answering relative's questions or just being observed by them sometimes interfered with our focus on these patients. Taylor's found those questions quite hard to.. [answer] and not being that experienced either, you know, you just palm[ed] it off onto someone else. (9:6,8-11) *I can remember when I first started there [in the unit] a more senior nurse just talking to the relatives like.. and I said, "Oh, that's a good role model, I'll have to listen to what she says."* (9:6,14-17) but because of a lack of continuity in the nurse/patient relationship and doctors' rostering, relatives received information from a great variety of staff. So when we attempted to answer questions, we were not sure what was told to them before and we didn't want them to receive confusing information. *It [was] just a minefield really, because not only [did] you [have] lots of different [unit staff] at lots of different knowledge levels saying different things, but also [the relatives were] interpreting them all differently as well.* (9:6,23-27) *And then what people [were] prepared to say to relatives [was] different too. Some people, even though they might [have known] a lot, [didn't] say anything, but anyway it still [got] interpreted.* (9:7,7-11) Being inexperienced, Taylor sometimes felt evaluated by ...a lot of the relatives, not a lot, but some of them are involved in health professions...they really watch you when you're doing stuff (9:6,30-31,34-35)

The dying Greek lady told by Taylor

I was up working on Neuro and we had a lady that was.. they knew that she was dying, you know, she was not NFR [not for resuscitation], I actually thought she'd go on my shift and it was a big Greek family, they were all in there with her and howling, you know, which is fine, its their way of dealing with it, but I remember, I was in there and the daughters and that were asking, you know, "What's she doing now?" and I don't know if you've ever seen a patient type of, they jump but they're still going, like their not dead and I thought, 'cause I'd never seen it, it was my first dealing with that experience, so I didn't know if she was still.. I had to go up and feel the pulse to see if she was still there, and the daughters going, "Oh, is she still alive? and I'm going, "Yeah, yeah." But I found that really hard 'cause the whole time they were going, "What's happening now?" and "When's she going to die?" "When?" you know, and she had a butterfly in her arm, so I was just giving her, she had PRN[whenever necessary] boluses, there wasn't any time limit, and 'cause I hadn't worked with her, I didn't know how frequent I could give it like and I remember just going up to the doctor and, I knew, I mean, they knew she was going to die soon and could see that she was in pain and I just didn't know, like if that little bit I gave her would pull her, or push her over the edge. I found it really hard and then the family being there and, you know, "What are you doing now?" and, you know, practically I was giving her last, you know, bolus. I wasn't killing her but I was making her comfortable. (9:12,36-13,32)

Relatives sometimes diverted our attention from the patient to themselves when they had information needs, or to ourselves when they intimidated us. However, there were other sources of insight available to help us understand these patients' experiences.

The patient was accessed via nurse's personal or imagined experience

Those of us who had personally experienced situations that these patients were in, used the insight obtained to connect with what these patients were experiencing. Others of us established a link through imagining what it would be like to be the patient.

Rhea's own experiences caused her to see pain associated with surgery I've had abdominal surgery and I know, you go to take a deep breath its sore, you cough its sore, you laugh its sore... it takes days to wear off and because we have the majority of people in the acute stage I think its important to be aware of (8:4,33-37) Even things we would consider less painful, just routine or a low priority, some of us had personally experienced. *I think we see so much that we think that the routine things are nothing, like having a cannula in, that can be really painful, especially if its tissued (8:27,7-10) I think that if you've had a cannula in or something like that, you know what it feels like... [but] because people are so seriously ill that you forget that they've got a cannula in, or a tube in their mouth even, (6:24,8-12) Rhea thought about how much heparin that we give and they're black and blue and we don't even consider it, it just doesn't come into it, you know, I suppose we do have to prioritise but those small things can make a difference too... well you're not looking at their abdomen all the time so you like don't see all these little purple scars or bruises until you give the next injection. You go, "Oh that must be awful sore" and then you know you their ICP [intracranial pressure] shoots up and then you go, "Oh, oh gosh" you know, and its not a priority any more (8:27,28-28,5) I thought *It's good for you, really to have to experience, I mean it's not nice but its good for you to go through something because it makes you much more aware of what you're doing. I'm not volunteering to be this type of patient in this sort of pain. (5:21,19-24)**

Drips and needles told by Rhea

I had a drip in my hand, it was the most painful thing I ever had and the drip was out like this and everybody kept knocking it and it was agony, absolute agony, my hand was black for days. And too another thing that I always remember was, I asked the nurse for, I hadn't had any analgesics the first night and I asked her for a, like I was fourteen, I asked her for can I have something to help me sleep 'cause I didn't sleep the night before, first night post-op. And she said, "Sure" and she came back and drew back the curtain drew back the covers and jabbed this needle in my leg and I was convinced she was going to give me a couple of sleeping tablets, fourteen very naive um and she jabbed this.. and you know that was more painful than my abdominal wound, it was agony, and I had to walk and everything and that was just an injection (8:27,12-28)

Blood gas told by Toni

I got.. one of my friends did a blood gas on me last year, 'cause I wanted to see what it felt like, 'cause, you know, I always used to say, "I'm just going to do a little prick, it'll hurt a little bit." 'Cause we used to do them all the time... I just wanted to check my haemoglobin just on a gas, so I thought, "Oh well," so I said, "Just do a blood gas." Oh, it was just excruciating, OK, it was terrible, it really, really hurt. I had pain radiating all the way up my arm. 'Cause, you know, how you always say, "Oh, it'll hurt a little bit." Ohh it was absolutely dreadful, it was worse than having a blood test or a cannula put in, really hurt and then it throbbled afterwards. And it wasn't as if she did a bodgie job, ' cause she got it straight away, and after that I've always been, "This will hurt"... I think you're better to be honest (6:24,14-34)

When we had not personally experienced situations similar to those in which these patients found themselves, we were left to imagine ourselves as the patient. Beth asked herself "Would I be in pain in this situation?" (7:2,2) Bryce thought you've definitely got to try and put yourself there to see, you look at the person look at how they're reacting and thinking, "How would I be reacting if I was lying like that, if I had this injury how would I like to lie." (4:5,31-35) Robyne also tended to try and place [herself] in their position, and [thought]... there must be some element of discomfort having all those tubes in, and every time you move it pulls a little bit, and there's that noise, and there's like, you know, that total.. I'd be totally irritated by the environment, maybe that accounts too for a certain amount of pain (3:3,2-8) Asha thought it would be important [to be moved] if it was you and you know, your leg was in

one position and it was sore (2:2,22-23) things like peri care and mouth care, can you imagine what it would be like to have all this saliva at the back of your throat and not be able to swallow it, it'd be just so uncomfortable (2:2,36-3,2) or if you've got thrush, having an itchy perineum, that would override any discomfort with an ET tube, I think, I mean, really that'd just be horrendous, or, just feeling dirty... if you felt you were sweaty or dirty or, you know, you felt you were smelly (2:3,3-8) putting yourself in their shoes, and as I say just little things like being on one hip for too long and.. Looking at somebody's position is another thing. Like looking at them, when you position them on their side and their head's bent right forward and their arm's right over like this, I mean you wouldn't be comfortable yourself if you were like that (2:3,16-23) **Bryce thought it was easy to minimise the impact of the tube on these patients** I think there's more discomfort than pain associated with that [endotracheal tube] than... we realise. I guess the majority of staff haven't had a tube put down their throat that's a half inch in diameter to see what it feels like, so, yeah, can we really sort of like say, "It's all right, you relax." (4:5,22-28) **Patrick specifically imagined suctioning an endotracheal tube** Well, your airway'd be so inflamed, like coughing while you've got a brand new cold, I guess, and you can't breathe in air. (5:5,27-30) **Bryce imagined being a patient post surgery.** "Look at this person. OK, so I'm gonna say, he's had a major abdo operation how do you think I would be feeling? Well, my stomach would be pretty well churning at this time. I'd want to be pretty bombed out for the first day or two, to get over this initial, real bad pain and then try and wean it down after that. OK I might be a bit bombed out and a bit spaced out, but I think I'd rather be bombed out and not feeling that because that's not going to be of benefit to me." (4:7,35-8,9) **Patrick's imagination was guided by what he thought might be happening at tissue level.** OK you have sutures inside of you and sort of sudden different pull in a different direction and you've got these three drains inside of you and sort of you're turned and they scrape around in there. (5:15,32-16,2) **I thought** *if you're lying there with your abdomen open its sort of like, you know, I guess I just try and imagine what it would be like, scraping a big hole in your abdomen, but being turned when you've had an operation so that the inside of you is all disrupted as well.* (5:15,26-30)

Personal experience gave us clear clues as to what these patients might be feeling, whereas those of us without personal experience had to rely on our imagination. We found our imagination was refined by empirical and theoretical learning.

The patient was accessed via the memory of other patients

Although we knew that patients were individual in their experiences, any similarities between these patients and awake patients that we had previously nursed, or patient memories of their ICU experience, allowed us to add assumptions of experience and personhood via what others had shared with us.

We thought that those of us who had nursed longer or seen more would have a better chance of connecting with these patients. Toni thought *if you've been nursing, you know, fifteen years or something, well theoretically, you should be able to sort of assess if your patient's in pain, a lot better than someone whose only been out a few years. But that just depends on your experience I suppose* (6:19,22-27) **Rhea had some suggestions on getting good experience as a nurse,** I think the thing to do is to go from different situations and learn and pool your knowledge when you get to somewhere where you're happy to stay and utilise everything that you've seen before (8:17,13-16) **But she thought experience wasn't valued by nursing employers,** its never looked too kindly when you're jumping from area to area either, you know, in your CV [curriculum vitae] I mean you just sort of do a year here and then you jump and I mean its all right to sit in an interview and say, "But you know I was interested and want to gain knowledge in

different areas and it was...” you know, you’re jack of all trades and you’re not good at anything and so people look now and see if you’re going on to get your degree and get experience in specialising in a particular area (8:18,7-15)

Rhea saw individual responses in patients she had nursed previously and those who were patients at the same time she was. She felt you can’t put yourself in somebody’s shoes unless you’ve been there and even then its individual (8:5,14-16) everybody’s level is different so, I mean, what I have if you would have it mightn’t be exactly the same. (8:5,37-6,2) I think more of my understanding would be listening to other people out there than from my.. it just gives you a better insight than someone who’s never experienced surgical pain.(8:5,26-29)

Different rates of recovery told by Rhea

at the time when I was in hospital, two other girls had the same procedure and I had been discharged two days before either of them and we all came back at the same time to have sutures removed, and one of them was still hobbling around. (8:6,3-6,8)

Toni also acknowledged that pain and things is very individual and I think we tend to forget that, like some people might have a procedure which we would consider as being quite minor, yet to that person its a big deal and they’re in lots of pain (6:22,29-32) Bryce agreed, people tolerate differently, the pain’s different for that person too. (4:21,22-24)

Cannula pain told by Bryce

she was having a lot of pain just with the cannula site. But, say, as compared to an orthopaedic injury that may be, only minimal, but to her that was a large issue (4:2,32-35)

The lady with the K-wire told by Toni

I once looked after a lady who had just something really minor, just had a K-wire put in her toe or something not very flash, and some small orthopaedic thing or something in an orthopaedic ward, and she was, well, appeared to be in so much pain, I thought something else had gone wrong, you know, like, I thought, I didn’t know what they’d done, and we got her reviewed and all this, and she was just in pain. She must have had a really low pain tolerance, I think. So we got her pain sorted out and she had some morphine and then I think we got her a PCA[Patient Controlled Analgesia] or something, it went that far, but... we just all thought, “Oh, she’s just you know, must be, you know, carrying on a bit.” But she was a bit of an.. not an undesirable person but like she’d been in and out of hospital a fair bit, she’d, you know, and they were querying whether she had like a previous drug addiction and those sorts of things, so we all sort of were trying not to give her pain relief. You know, people sort of thought, “Oh well, you know, she’ll get addicted to it.” But she was in pain obviously, she wasn’t just sort of, you know, bunging it on. But it was just like, not just a K-wire, something very simple, you know, nobody believed her until we got her reviewed and the orthopod said, “Well, she could actually be in lots of pain, you know” And you actually treated her and she stopped and she was fine – a very pleasant lady, you know (6:23,17-24,6)

Knowing about individuality only tempered our assumptions. The individual response was not available to us in these patients. We assumed experience based on similar patients we had nursed before. Some of these assumptions included grouping patients socially or culturally. Beth thought, sometimes really really old people don’t have as much pain (7:2,3-4) on the other hand, Toni knew kids have a total different perception of pain to adults (6:8,23) and Robyne saw male’s pain experience as worse than female’s, you know what men are like when they’re in pain (3:4,10). Toni believed a lot of Asian people don’t ever sort of, acknowledge that they’re in pain, they’re quite reserved and, you know, quite stoic about things, and also some sort of Arabic and Moslem people are just very loud and, you know, but that’s just their culture which you have to take into account (6:9,8-16). Toni also saw patients who had been hospitalised quite a lot, react to pain a lot different to people who’ve never been in hospital before (6:9,30-32).

Pethidine addict told by Toni

she used to drive, come to the triage desk, you'd know it was her, she get seen by the doctor, written up, have it [pethidine], and then she'd go. You'd used to make her try and stay for 4 hours but she never would. You couldn't forcibly you know, and it didn't use to affect at all, so she'd just go out the front and jump in her car and drive. Oh, it was just unbelievable, and she kept just doing that all the time, you know, until she lost the plot one day and ended up in the psych ward, but I just couldn't imagine it. She was.. and that was just a total different.. oh she said she was in so much pain, so oh, uncomfortable and those sorts of things, and yet in the corner would be this little old man with his NOF[fractured neck of femur] and he wouldn't, you know, wouldn't make a noise, you know. (6:10,25-11,2)

We also grouped patients by pathophysiology and held expectations of their experiences based on patients we had previously nursed with similar conditions. Bryce thought if someone's broken their leg you think it'd be painful, nup I've never seen, I've never given the amount of pain relief for that as I've given for renal colic because ah but well I think that that was one situation where different pain has a different pain, and people subjectively think a broken leg's worse, but its not. (4:21,27-33)

Taylor's opinion was that if you're new and you haven't got much experience and you haven't done, like I haven't done many oesophaguses, the two or three that I've done now, when I've looked after have been extremely painful, you know, and so that's what's in your system to go on, like that type of surgery must be very painful, especially for suctioning and if you haven't dealt with that type of surgery before you don't know other than the obvious how that person's pain is during procedures (9:22,21-31) now I've done that procedure before and that person was in tremendous pain so this person would have to be in a bit of pain, I'd at least think like that.

(9:22,7-16) Rhea had worked in surgical ward for a long time as well, and any post op patient has, any surgical incision has pain attached to it, in particular, you've got to think of where the incision is as well as to how the continuum of pain. I mean, obviously, if its something like a hip replacement they're going to have pain when you roll them on that side initially but the main majority of pain is going to be when you start to mobilise. Well, we don't do that but you've still got to consider we have them at the acute phase so I mean, if they are with us for may be nine or ten days because of a chest problem and can't go to the ward you're not looking at surgical pain and that's from experience that you learn that and listening to other patients with different conditions. Its not something you just know its listening to other people. (8:4,9-25)

When patients talked to us about what they remember of their experiences in ICU, again we took that information and applied it to other patients in similar situations.

Turning a multitrauma patient told by Nerilee

she came back [talked to us in an afternoon tutorial] she was a multitrauma, had fractured ribs and a flail and... fractured limbs and she couldn't remember much either, but she could remember being turned, which she said was really painful being turned, really painful. But just like she just didn't know anything and then all of a sudden she was being turned and she said it was like just falling down into a big deep pit 'cause it was just so painful. (6:15,18-26)

Suctioning - just one more time told by Nerilee

I was as at a conference, one of the guys, it was at another ICU, came back and he was talking about suctioning being really really dreadful, I don't know, whether he said it was painful, but he said that he felt like he was choking, and he also said that physios were a lot more gentler than nurses. I went back from that conference thinking, "Oh, I should be very gently now with the suction," (6:15,30-37) and he said he hated it when they said "just one more time." How many time do I say "Just one more time."? All the time (1:10,21-23)

Suctioning - can't catch your breath told by Rhea

we were at a respiratory conference actually a couple of months back with the unit and the guy there said he spoke to a patient who said it was like the living air had been sucked out of him and every, you know when you cough and you have something caught in your throat and you cough and cough and you just have to try and catch your breath, but you knew it was going to happen, he was describing it as a fact that you'd sucked every last drop out of him and he just felt that he was never going to get a breath because the suction catheter had taken up everything, you know, and so if you think you're doing that every hour or more frequently on the patient, I mean, they must be just exhausted, you know, the mental anguish you go through at the same time and you think that with this and you can't catch your breath, you know, it would be horrible. 'Cause I mean your basic, your basic instincts are that you breathe, breathe, breathe and you just can't do it, it must be horrible. But yeah, I have remembered that. But how do you suction more gently, I mean, there is a point where you just don't ram the catheter down and back up again but... the quicker you can actually do it, its probably the more sensitive thing to do. (8:28,18-29,4)

Because some patients remembered experiencing awareness and pain while 'unconscious' and talked about it after recovering, we saw these patients as aware even though they looked asleep. Asha's opinion was I don't know how aware they are of that though, so I guess we've got to assume they are (2:3,8-9) Rhea also thought Whether we can't see it or not, mentally they could be feeling all that (8:3,2-3). Petra thought especially if they're paralysed, you know that they're going to be feeling something underneath. (10:1,30-31)

Insensitive doctor told by Asha

he's had most of his frontal lobe removed, he[the surgeon] was saying, "Oh, I'm not saying that he's going to be any mental giant, I mean, just look at him, you know, but I don't know if we should pull out on him.", and they were all just quite coldly talking about pulling out on this man... Right over the top of him (2:12,14-19)

Patients hear told by Asha

she wrote them a letter or went and saw them later or something like that and spoke about conversations she'd heard around the bedside from the nurses and things she'd felt, pain she'd felt, all this sort of thing and she was there for a long time... you know, and they were sort of saying, "So be careful, you know, you don't know what the patients hear.", and certainly I go along with that, you know, I think you really have to do be careful (2:12,4-12)

Patients remember told by Leticia

the guy that ended up down in iso with the pancreatitis, the gentleman that didn't speak much English and we thought he was going to die so many times... He was there, he was so sick, so long, and when he was better and was going to the ward, a couple of times people went down, [nurse's name], that's right, he said to her, "Oh, you're the girl that did my toe nails.", and things that she thought he wouldn't've remembered but like he made comments about things that a couple of them were quite shocked about, but he remembered and he knew (1:9,10-19)

Patrick thought we could have encouraged patients to come back to talk about what they remember, although he was realistic about what might hamper them. I guess to gain more idea about it maybe we should look at, oh I guess you could always do it on a voluntary basis but maybe ask more, get their side of the story more (5:21,26-29) I guess, it would be, it might be interesting to sort of... get patients who've we've had in for a long, or like for a reasonable amount of time and like talk to them about their experience in depth. I do know some of them come down and... they've talked about it and said, that you know, "Thanks very much and we got really good care here." But I guess it would be interesting to ask them specific questions about whether they were in severe pain at any stage and did they feel pain, but were unable to like communicate that they were in pain and stuff like that. Whether they're at that time would be honest with you could be difficult to say, because it'd be pretty hard to walk into a place like that and say, "Oh, guys, you're doing it all wrong." (5:4,14-32) Toni often wonder[ed] what people do remember when they're out of it, like whether they actually do remember you going up and saying, "I'm going to turn you now Mr.," you know, or whether that you just midazolam them out, or, you just don't know what they remember. (6:15,10-14) and she thought it

would also be very individual as well. You know, depending on what they've had, and those sorts of things, to what they remember and you really wonder if it would be not sort of precise, if they have had lots of midazolam whether they're just kind of guessing at what they felt, you know, like, whether they're just sort of thinking, "Well, yeah maybe I was in pain, or maybe I wasn't." (6:16,24-31) **I agreed that patients' memories helped us in our care, but I also thought there was more to the picture.** *There's been research on people remembering and pain I think was the second highest memory... but then I have problems with research on patients' memories because a lot of people don't remember because they're not alive or they're in a different sort of state with their head after being in ICU and what is the point whether somebody remembers it or whether they actually experience it at the time? That's my point of view. So they could've been in horrific pain and not remember it because we've given them some midazolam but at the time it would have been horrible.* (1:17,8-20)

Our empirical learning included awake patients and the memory of ICU patients. We also used our knowledge.

The patient was accessed via theoretical knowledge

The times when we may have not personally experienced, previously cared for awake patients or heard patients relate their experiences of similar conditions, our theoretical knowledge was used to connect to the processes happening within these patients.

Many of us looked at the physical tissue injury the patients had sustained and saw pain connected to this. *I base my assumption [of pain] on nociception, ie that their tissue has been injured eg by incision, pressure, anoxia etc. I also think that movement would increase pain by causing stimulation to the nerves around the site causing pain. So the times I would be most aware of pain in this type of patient would be on turning the patient or moving any body part (especially injured parts), doing dressings and suctioning (which makes the patient cough causing major body movement)* (Nbview.doc:1,9-16) *if you were going by the things that would cause him pain, I mean hypoxia would be really uncomfortable, sort of trying to breathe* (3:7,28-30)

Leticia thought about how much pain the type of procedure that they've had would cause them. (1:13,18-19) *I guess the only thing I've been told is that anything going through your rib cage is really painful like intercostals are really painful but I didn't know about where like where the incision was or how big it was. I suppose you just assume, don't you?* (1:14,6-10) **Robyne also considered** the type of surgery or, you know, their disease process, for example, if you've got a person that's been in a car accident with multiple fractures, you know,

there's an assumption that they are going to be in a lot of pain and if they're not doing anything, you know, you would give them a bolus [of narcotic] before you moved them or do any procedures (3:2,1-6) **Petra looked at all possible causes of tissue injury in a patient that is unable to respond due to, pathology, that could be another indication.** I think you have to always assume that, or like look at their actual underlying pathology and in most cases assume that they will have some degree of pain and discomfort um, even just from being in this sort of situation. (10:2,29-34) being confined to a small space, being turned every two hours, being wakened up every five minutes. Having things jabbed into them, tubes, like whatever tubes, whether its ET's [endotracheal tubes] or NG's [nasogastric tubes] or catheters or whatever, and just, you know, even lots of tape and stuff all over them's going to make them uncomfortable. (10:3,2-7) if they've got a huge surgical wound then the chances are they're going to have pain, they've got a big subdural haemorrhage, then unless its too big we'd have knocked off their pain centres as well, but you know blood in your subarachnoid space is going to cause pain like that sort of thing. (10:4,8-14) **Toni's patient** had some major type of surgery, you can, you obviously think, "Well they probably will be in pain." You know, some big procedure or something (6:2,7-10) I mean, he's got a huge abdominal wound, and obviously he must be in pain, well I would assume he would be.

(6:14,16-17) **Patrick also supposed** when they have huge dressings and stuff like that you sort of go, “Yeah, they must be in a little bit of pain or something.” (5:15,20-22)

Because of tissue injury, we often assumed these patients were not comfortable or in pain, even though they looked comfortable. I thought *all of these type of patients would not be comfortable* (NBview.doc:1,9)...*somebody can have a, like a really massive headache or something and be lying still and not responding* (2:13,26-27) **Leticia thought** pain is something that they all experience, and discomfort, especially if they're an unconscious intubated patient (1:1,36-2,1) **Asha supposed** they still feel pain. That's the other thing, they just can't communicate it (2:2,23-24) **Rhea thought** they're uncomfortable as it is, so it doesn't have to be physical pain, but I know that that tube in your mouth could be so uncomfortable (8:6,30-33). **I assumed pain, especially** *when they are not receiving analgesia, eg first back from theatre, or when analgesia is not ordered by the doctors.* (Nbview.doc:1,18-20)

There were specific signs that indicated to us these patients were uncomfortable or in pain. Knowing that pain causes stimulation of the sympathetic nervous system, we noted hypertension and tachycardia. Petra thought their blood pressure and heart rate, they're the two things that can sort of indicate if they're uncomfortable but unable to express it. Hyperventilation (10:1,35-2,1) **However Rhea and Beth were aware of different causes,** tachycardia for any other unexplained reason and a rise in blood pressure for any other unexplained reason that you can't think, (8:6,17-19) tachycardia, but then that could be a sign of bleeding too, so you can't just go on that. (7:2,6-7) **Toni and Robyne noticed these signs while turning their patients** they're getting really tachycardiac when you turning them (6:2,1-2) If they become like really tachycardiac or hypertensive when you're turning too, you know you start to think well, you know, what's going on here? Pain, you know (3:3,21-24) **Whereas Asha changed her patient's position in order to treat these signs** I always say, you know, if somebody gets tachycardiac and hypertensive and puts their pressures up, it might be something as simple as they're uncomfortable, and sometimes just simply moving them fixes it (2:3,26-30)

Sympathetic nervous stimulation also caused diaphoresis and dilated pupils.

Beth and Rhea thought sometimes when they're in pain they get a bit clammy. (7:2,14-15) sweating, you know, you often see people are a bit sweaty when they are in pain (7:8-9) they might not be able to move at all but then they have this huge sweat and if its not for an unexplained, for any other reason, then you've got to consider the fact that it could be... pain. (8:6,36-7,3) they sweat even when they're paralysed. (8:7,10-11) **Beth considered** pupils size sometimes could be a bit of an indication too. Especially in somebody like this who is unconscious. If they're large they could be in pain, but also frightened too, so may need to be given a bit more sedation (7:3,10-14)

From our knowledge of pain behaviours, we interpreted the few signs these patients exhibited. Bryce relied on body language, because that's as far as we can get most of the majority of the time (4:4,30-31)

We thought these patients looked uncomfortable when they were restless. Bryce thought if they're moving about a lot and trying to get comfortable themselves, then obviously we haven't put them the way they'd like to be, we haven't give them the relief that perhaps they really need. (4:4,36-5,4) **Rhea noted when these patients were** moving their limbs, irritably reaching for tubes and stuff, (8:6,29-30) that type of patient can't say I've got pain but you know they're telling you because of their agitation

or they're moving around (8:9,36-10,1) you automatically know that if they're starting to get restless and irritated and you know that they're its probably pain or discomfort from the tube, or discomfort in the bed. Change the position or whatever (8:10,8-12) so in a way you sort of look at that as their way of telling you bar all that writing, pointing, telling you.(8:10,19-21) **Bryce suspected that** its almost like they're trying to get at you somehow, like trying to pull their tube out, its like, "I'll get this person, I'm uncomfortable and I'll get him." ...they soon figure out what's the best way to extract as much attention as would hopefully get their desired result. (4:5,7-10,17-19)

We equated comfort with relaxed muscles. Beth noticed sometimes when you're moving them if they get stiff, you know, all tensed up... that's a sign of pain (7:2,8-10) **Bryce found** you'll go to roll the person, they'll be very tense (4:3,12-13) when they encounter something as stressful as being tubed and so forth and us having literally total control over their body and what we want to do with that body, how we want to manipulate that, they get very tense, which is a physical comfort and pain issue. (4:3,17-21) I think you can actually feel it in their muscles if they're nice and flaccid then you think, "This person's nicely relaxed." They, as far as we can tell, haven't got any physical pain that's making them tense and rigid and trying to guard this pain (4:4,31-36)

All of us saw facial grimacing as an obvious behavioural gauge of pain. Beth saw these patients react to procedures when you're moving them, oh well, just for coughing and suctioning, you can see them grimacing, facial movements, you know the sort of expressions (7:2,10-13) **Taylor thought** obviously gritting their teeth, they're in pain, if they can't communicate.(9:2,22-24). **But Robyne attributed a lack of this reaction to being** quite sort of out of it, I think, if they can't even grimace (3:6,5-6) I think you'd have to be in a very deep coma to not be able to grimace when you were in pain, because patients that you even apply painful stimulus to who aren't obeying and they're flexing or extending, those patients who like score very low on their coma scales, they still grimace when you do that type of thing, so, yeah I do. If they're not grimacing, and maybe this is a wrong assumption, but maybe, you know, they're not perceiving pain. (3:6,9-18)

However, according to some of our medical colleagues, grimacing does not mean pain in uraemic patients. Robyne and I talked about uraemia and grimacing, ...they've [these patients] got that like grimacing, and they [the doctors] always say, "Oh its just the uraema," you know... its supposed to be quite painful, isn't it, just the uraemic state. *Yes, apparently, just to touch somebody... its associated with fitting, like your high uraemia...But I don't know whether that means as it gets lower it would be twitching, but I still don't think that twitching equals grimacing... why does uraemia cause pain? Its something to do with the skin, I don't know, I'd have to look it up...* I remember people have said that to me to, as well, "Oh, its just the uraemic state, don't worry about it." (3:12,32-13,28) **My dilemma was that** *I'm not convinced that that grimacing is not pain, you see, and when they're not on anything and you can't give anything when they grimace and that sort of concerns me a lot. But I guess, that um, I don't know what, and I guess I haven't really learnt about what if you give somebody with liver failure some stuff some morphine, and the metabolites are running around their body what is that actually doing, is that making the liver worse or is it just that they're going to be asleep for longer afterwards, and if that's the case then why can't we stop the pain now, because they must be experiencing torture if they can't have [narcotic analgesia] you know, that sort of tossed it all up and think, "Oh, what am I doing here?"*(5:14,15-27)

Bryce and Toni considered whether the pain that these were assumed patients to be experiencing was acute or chronic, as this differentiation impacts on what management would be effective. Bryce commented I mean, then you've got to look at it, is it acute or chronic pain because there's a big difference on how to manage acute and chronic pain. So, I mean, chronic, you're starting to look at sort of larger doses again, and the use of alternatives especially, whereas acute pain is mainly sort of directed at plain narcotics and maybe a little bit of relaxation. So you've got to look at how long that pain's there for (4:11,29-36) Toni also felt there was a difference when I used to work in emergency, people normally came in a very acute phase, and then in contrast, you always get your chronic, long term back pain and those sorts of things, and I think, just being able to, you know, recognise, what this person's obviously in, you know, acute pain and see what type of analgesia works compared to sort of chronic long term people and when we used to get oncology patients in you could sort of see the huge doses they used to get at home and then you know that obviously its not working when they still come in pain and uncomfortable so.. I think just sort of getting quite a broad look at different ways people manage pain (6:7,29-3) Bryce was full of perplexing questions I guess its hard to determine, the longer term patients that get unwell, OK they're unwell to begin with, but their condition worsens, what kind of pain are they in now? OK they're over their acute stage of someone sort of slicing open their abdomen, but what type of pain are they in now? I mean that's a difficult thing to try and comprehend I think. I think sometimes patients go beyond the scope of our imagination and experience... I guess, hopefully all the nurses there are well enough not to have experienced.. OK they may have had a big operation but have they gone into renal failure and have they gone into multi system organ failure, what kind of pain is that? Is there a pain, I mean, there's got to be pain with it, but is it, is it a real sharp pain, is it a dull pain how do we best get rid of that? Do they need, I mean, how do we wean their infusion down to a level that's keeping general body pain not the specific incisional pain? (4:12,3-22)

We thought education within the unit could improve our theoretical knowledge. I thought we could have been educated on *the importance of pain management in these patients because of the detrimental effects of pain - stress response - deterioration in condition etc. Don't use pain to keep up BP[blood pressure]* (Nbvlew.doc:3,32-34) Whereas Bryce was more interested in education specifically directed at people that are non-purposeful and how the staff perceive that pain and ways you can overcome that pain for the patients because I mean, there's pain management things out on the wards, for say the oncology wards and the orthopaedic wards... but that's a little easier to assess up on the wards and they haven't got a tube jammed down their throat. (4:22,32-23,4)

Understanding the pathophysiological process within these patients allowed us to make educated assumptions about their experience of comfort and pain. Still, time with these patients allowed for improved connection.

Time spent with the patient increased the possibility of connection

On a one to one basis, as we spent more time with a particular patient, we were able to create a more distinguishable picture of that patient's experience.

Pre-operative visits would have helped us know these patients better and would have helped patients be prepared and thus more comfortable with ICU happenings. Leticia thought we could have patients come down and see the unit so that when they came around post-op they could see, you know, have a bit of understanding about what they were going to experience (1:10, 36-11,2) Its like everything, the fear of the unknown is an incredible thing so if you've got no idea, at least if you wake up you feel this thing in the back of your throat, you might somehow think this is the tube they were talking about. I

mean, maybe there's a connection, maybe there isn't, I guess you don't know, the individual will respond differently. So maybe if by just - maybe if one in ten was helped by it we should make a greater effort to do it (1:11,10-18)

Leticia said after my first initial hour or so with them and I can see that that's distressing for them (1:3,33-35) **Our eyes were focused on these patients throughout the shift, as Toni said** you've been there 6 to 8 hours and you know how your patient's been going and you can sort of assess them and I think, get to know your patient a lot better than the people who come around and sort of do their rounds, you know, twice a day, 'cause you're there, you see the changes and you see what happens when you turn them, and how it affects them, sort of even just their heart rate and those sorts of things, you know, where they start breathing up a bit more and those sorts of things and, you know, when the physio's there if that causes them lots of discomfort and things, (6:6,16-26) even when you're suctioning people and things, it must be really awful and uncomfortable and, I mean, if you'd had huge abdominal surgery, the last thing you'd want is somebody to be tipping you over every couple of hours, you know, and that's when I think our, we obviously see things. (6:6,1-6) **and over days or weeks, as with Asha's patient** I just think if you watched him, you could pick up especially 'cause we had him for a long time (2:4,10-12)

The longer the look and the more the eyes have seen before, the closer to 'reality' was the view.

The nurse/doctor relationship impeded connection with the patient

Although, the doctors spent considerably less time than us and had restricted scope in contact with these patients, they enjoyed a higher and more powerful status within our unit and were perceived by some of us to have superior knowledge. Doctors were legally in control of administration of medications. At times they either withheld or limited administration of narcotic analgesia or sedation and sometimes discredited our judgement of these patients' comfort and pain experiences.

Although the doctors were in contact with these patients for a much shorter time than us, they did not acknowledge our contact time as an important assessment factor. Toni **thought** at times they don't really take into account that you've been there all the time, like I think that they should actually try and discuss with you how the patient's been going, 'cause, you know, they just come along and say, "Well we'd better stop the, you know, sedation or stop the analgesia or decrease it or something." You say, if you could, if they would just listen to you a bit more I think, 'cause you've been there all day and you know how your patient is and *why you've got them to that state at that time* to that point, time, *what's happened just before*, exactly, so I think as nurses we're not often, sort of given enough credit for being able to ascertain how uncomfortable your patient is or how they're too comfortable or whether they're getting too much pain relief or not enough. (6:6,33-7,10) *So as nurses we're not really probably recognised as much for that continual assessment, whereas the doctors come along and do the five minute assessment type of thing and go by that.* (6:6,28-31)

The preparation for the contact time between doctors and patients impeded accurate assessment. We made the patients 'ready' for the doctors, *they're not there to actually deal with the time that they look like their in pain. Cause, you know, when the doctors come around they're all nicely on their backs and ready to be looked at.* (9:11,31-35) **Toni thought the doctors** normally come along just when you've given them [the patient] a bolus or something, 'cause you've turned them and they think that

obviously they've been like that all day. They come just when, you know, you've given them that little bit too much of morph and they're asleep, then they say, "Well that's it, no more." You know, and you just think, "Oh, if they were there for 24 hours, they they'd know that this person is uncomfortable and is fully with it." but, you know, yeah its hard. (6:5,20-29) **Doctors also tended not to intrude when we did our nursing work.** Taylor said, doctors... they're not there doing, seeing the patient all the time and understand it. (9:11,21-22) they don't see the procedures going on and the eight hours of the day that they're not there. (9:12,1-2) *They're hardly ever there when you're actually doing turns too, 'cause that's when you inflict, well when the patient would be the most uncomfortable.* (6:5,31-33)

Analgesia for grimacing told by Nerilee and Rhea

there's no show of anything when you do the dressing, but when he was turned the girls said he had a grimace, so if he was written up for something [analgesia] then, like, I couldn't understand why the next day he was written up for something before dressing but not before procedures like not before turning, that's when it was indicated that like. Like it was obviously just not thought about. It was just oh well, you know this soothes our conscience. You know, it should be before, he should be experiencing pain during the dressings so that's what we'll do rather than assessing what he's actually doing. (8:12,34-13,9)

There were several indications that the doctors continued to enjoy a higher status than us. Some of us assumed the doctors knew best anyway. Taylor thought I haven't been working long enough to know more so the levels to give, if you know what I mean? Like I'd probably think, "Oh well, the doctors ordered that, I shouldn't question that (9:10,29-33) Rhea suggested we would benefit by other people's experience like the intensivists to give us guidelines, (8:7,21-22) Advice from doctors considered experts in the area of pain was thought to be beneficial. Leticia suggested its difficult to know what to give and what to recommend, and maybe using the pain teams more often would be more effective (1:12,17-18) Others played the doctor/nurse game. Beth thought its, you know, what the doctors say. You have to go along with it otherwise "you're rocking the boat" and upsetting everybody. But, there again, if they're absolutely, well, I'm forgetting that they can't indicate... although if you felt that they were in a lot of pain you'd could like try and get somebody to review the order and assess the patient, but.. (7:7,4-11) Patrick thought we could be a little bit more pro-active but then I think there's also, people are probably a little bit afraid of what the reaction is from the medical side (5:9,37-10,3)

Legally, doctors have been given the responsibility to control medication. However, with the discrepancy in assessment, we were left to deal with restrictions on the amount of drug we could give and also had to cope with nursing a patient we thought was in pain. *Doctors control the most effective method of pain management – analgesia. In our unit, morphine is most often ordered as an infusion and titrate to level 2, meaning mild pain on nursing procedures. This gives nurses a degree of autonomy during the normal course of events, however, in some situations the autonomy is removed. When the patient is to be "woken up" for neurological assessment or to wean ventilation, if the patient has some sort of contraindicating condition which prevents them receiving normal amounts of analgesia or then get none at all. During these situations, nurses are faced with a full 8 hours of managing a patient who would likely be in pain, whereas the doctors, who have left such instructions, may appear at the bedside once or not at all during that shift. (Nbview.doc:3,17-27) I guess for me, its 'cause we're at the bedside all the time so you see what its like for them all the time, whereas the people who are actually imposing that restriction on you sort of come along twice a day, they don't have to be there..(6:5,15-18) And its hard too because, there's certain things that we can do to make them comfortable, but the ultimate pain relief, analgesia type stuff is all controlled by the medical staff. (6:7,12-14) Beth was guided by the doctors orders but believed more in her*

own assessment, people do come round and say “Well, they’re not purposeful or responding, they’re not in pain, they’re not to have any, so then, yeah, I suppose I’m guided by that too, because if one of the doctors comes around and there is one particular one that will come around and say that they’re not to have any analgesia because they’re not feeling anything, and he’ll say that even with some of the head injuries that have been paralysed, he’d say, “Don’t give any morphine or midazolam” so it is hard. There again, I suppose I’d just go on whether I feel that if they’re becoming tachycardiac when I’m turning them and things like that. (7:6,2-14)

Stop analgesia to wake up told by Asha

they want to wake them up and they’ve just had major abdominal surgery and they say, “Stop everything.”, and you go, “Hang on, you know, if they were on the ward they’d be getting four-hourly morphine or pethidine.”, its just that they can’t tell you, but no, they want them to wake up to get the tube out. Well surely there’s a fine line where you can still.. obviously, there must be because we give people morphine who are conscious and breathing but yeah, we forget. (2:12,34-13,6)

Disagreement in assessment told by Asha

I remember us nurses standing around the bed and arguing with the medical staff saying, “They must be in pain.”, you know. And they were saying, “No, look at them.” And we must.. obviously we didn’t have pain relief up, but I remember they’d just had like a triple A or something like that and they them saying, “No, we don’t want to give them anything.” And us saying, you have to give them 24 hours at least or something like that (2:14,10-17)

Paralysed without morphine told by Asha

I remember one night having a screaming argument with the registrar in another ICU I worked in, because he just wanted to give a tiny bit of morphine to a paralysed patient and saying, “You have to give them something sedative as well, you know, all the narcotic will do is just make them drowsy. You can’t paralyse someone..” and we paralysed this patient just on a bit of morphine and we just had this screaming tachycardia, went really hypertensive and I just said, “We’ve got to give them something.” and we were just pouring in the morphine, this was horrible, and we just.. he was a huge big islander boy, and he we he wasn’t ventilating and, even though he was paralysed, he was just obviously awake under the paralysis and he was just.. it was really horrible to see him, we were trying to get the morphine in and what was happening was, we had the morphine on like a biflow and the morphine must have been running up into our maintenance line. So he wasn’t even getting any morphine. Oh, it was just horrible, and I ended up just getting a syringe, ‘cause I knew he mustn’t have been getting even the morphine, pulling the morphine out of the bag with the syringe and injecting it into another port, so I knew he was getting it, and he settled down eventually. But it was just horrible, you know and medical staff had gone and they just didn’t seem to think it was a problem when we told them about it afterwards, and that’s terrible. (2:8,28-9,16)

Sometimes the management instructions from the medical staff for neuro patients were unclear. Leticia was not sure whether or not they want them completely sedated or you’ll have a conflict of guidelines and that sort of thing. So sometimes, you know, neurosurgeons might say, “Keep them flat.” and intensive care people say, “Keep their ICP [intracranial pressure] below something.” and if that means that they’re a bit more awake then, you know, what do you do? (1:14,28-34)

The doctors control of medications together with their perceived superior status and knowledge were barriers to our connection with these patients.

Individuality of connection achieved

Because we came with varying backgrounds, we were different people, had divergent experiences and dissimilar knowledge levels, we had unique abilities to connect with these patients.

Petra said its sort of a mixture of what you’ve been taught and what you’ve experienced along the way. (10:4,33-35) Bryce thought we remembered patients that you’ve looked after in the past and how they’ve reacted to similar situations, and I guess, depending on where you’ve worked and what kind of patients you’ve worked with (4:9,5-9)

This individuality was evident when we elicited help from our colleagues. Leticia asked when she was not sure, “Do you think I should give this do you think I should give that?” (1:7,24–26) Patrick sort different views on nights and you sort of say, “This patient just does not look comfortable.” And you ask people, “What else can I do?”, or like people say to you, “Oh, I just can’t get this person comfortable, he just doesn’t look comfortable.” (5:24,4–9) Leticia thought its something that you can only manage well when you’ve had lots of experience at doing it (1:2,2–3)

Individual advice told by Bryce

if you ask someone’s opinion too, there can be a difference like three or four mls an hour[narcotic infusion] which is a fair bit, I mean... when you consider it over say (24 hours) I mean even two mls over 24 hours I mean that that’s 48 mgs of something, that’s a lot of relief... that’s subjective, obviously that person either feels that, “No, he hasn’t got any pain.” or “God, he must be in a lot of pain with that.” (4:13,24–32) if you had the one patient and got four people that were on that afternoon, I’d lay a bet that you could a range of say.. if it was sitting there on say five and said, “Do you think he needs more or do you think he needs less?” and if you put a case down, the exact same case to each person, I think you could go from say about, a low of about three, one person saying, “No, I think you could start to wean it down a bit.”, whereas a person may say, “No, keep it as it is, that’s fine.” and another person saying “No, I think I’d increase it one or two just to see how it goes.” (4:14,6–16)

The ultimate connection between these patients and ourselves occurred when we relied on instinct or gut feelings. Bryce thought I guess there are those that can’t move at all... its a feeling one I think its not a looking one... you’ve got to try and start to look at subjective feelings (4:13,11–16) I think there is a gut feeling, and everyone’ll say go with your gut instincts, because more than often you correct in those instincts. (4:14,1–3) Toni sometimes you can just tell if you patient’s in pain or not... just sort of like a gut feeling (6:2,4–7) Beth rationalised gut feelings I suppose probably just an instinct you get... and it most probably is more an association of the conditions that they’re in and would I be feeling pain in that situation. (7:2,16–19) Patrick summed up the assessment process I think its a guess combined with compassion combined with the fear (5:23,21–22)

The connection achieved was as individual as the nurses and patients involved.

The inadequacy of documentation

We found the complex interrelation of what we observed in these patients, what we knew from our experience and learning, and what we gleaned of their personhood was unable to be contained within the one specific chart available for documentation of pain and sedation.

Leticia realised that those categories are fairly inadequate (1:2,24–25) you can have lots of experience, it can be quite difficult still to actually categorise what the patient’s experiencing and where they’re at (1:2,35–3,2) And just having had a look at a couple of the charts in the last week, I think they’re really poorly filled out. (1:4,23–24)

Categorising told by Leticia

the patient that I looked after last night was a head injury who could move her left side but wasn’t conscious and was quite purposeful with her left side and would have extubated herself yet she seemed distressed and it was difficult to know whether she was awake or some sort of level of unconsciousness and whether or not she was in pain or she was in discomfort it was fairly difficult, and then when you had to write that on a chart, was she awake or was she drowsy or was she unrousable? I found that really difficult to categorise her (1:2, 24–35)

We found the paperwork available for comfort and pain was inadequate and thus not effectively used.

Quest for objectivity

We fantasised about an effective, objective assessment tool which would measure these patients' comfort levels.

Some of us had ideas on how this could have been achieved. Leticia offered maybe using more physical signs of grimacing or, you know localising to pain maybe something like that would be more effective than standing at the end of the bed going, "Oh, they seem to have mild pain." (1:15,4-8) Robyne suggested, maybe, it'd take a hell of a lot of research, you'd have to like invent a computer software package to do it, and get everyone's statistics from every operations and get them to say, "Oh how much pain did you experience?", and at different stages and somehow come up with this thing in the end which says, OK. you had a carotid endarterectomy, you should be experiencing this certain.. you know and then like is that applicable? I don't know. (3:14,14-24) Patrick offered, maybe we could have just like a little BSL [blood sugar level] with like have a endorphin sort of easy test (5:23,6-7) but he conceded I guess its difficult because everybody experiences it differently. even if they could measure it whether the actual experience is, cause its to do with perception as well and it would change from, like from day to day, and sometimes you'd have a really positive day and you can sort of put up with these things, sometimes you just go.. Yeah, so we continue to guess (5:23,13-20) I didn't think *there is an answer, unless somebody does some medical research and finds some chemical or neuro transmission or something that equals pain. And then it would be measured like an arterial line measures blood pressure, but I don't think that they will* (3:15,3-10)

However, the realms of fantasy did not help us deal with the reality of nursing these patients in this situation.

Goal; commitment given to providing comfort and alleviating pain

Based on our connection with these patients and what we believed our job to involve, we had different levels of commitment to helping these patients be comfortable. Leticia thought it's a human instinct to a certain extent, you see someone in pain and you want to stop it. (1:12,33-34)

The nurse's skill was measured by the patient's comfort

Either by judged our peers or within ourselves, caring for a comfortable looking patient showed that we were good nurses. Although, at times it was not possible to achieve, we were motivated to attempt to reach this outcome.

If we were good nurses, our patients looked comfortable. Rhea described comfort as occurring when you get to a point where you're maintaining an acceptable sort of blood pressure and heart rate and the patient is, you know, looks physically calmer from agitation (8:6,26-29) Whereas Bryce thought they can still in a sense show that, "Yes now this is comfortable that's great." and then I think you've reached a state that's good keep it at that. But, if you've reached the stage where you can totally manipulate them, and you could make them into a into a contortionist and they don't mind then, you've gone too far. (Laugh) That's a bit of an exaggeration (4:7,7-13) Asha thought that nursing [was] a skill on its own...we [were] there for patients' comforts and I think that [was] our skill, looking at the patients, trying to get them comfortable (2:4,20,26-28) Patrick's opinion was that it [was] a very big issue in your training and I think that it [was] very hard for nurses to measure how effective they [were] and one of the very few things

that we [could] sort of have a direct measure of what sort of job we [were] doing is whether someone [was] in pain or out of pain, painfree (5:23,24-29)

Comfortable patient told by Asha

I remember one of the girls in my critical care course, beautiful girl, really lovely, she used to be a nun until she fell in love (laugh) and she's one of those girls, you know, we all used to say if you were ever sick, the first person you'd have look after you would be M, she was just wonderful, little Irish girl, and I remember the charge nurse, well one of the girls, the associate charge nurses in coronary care was really big on having everything clean and tidy around you're bed and she came up to M once and she said, "M you're environment is a mess." and M looked at her and said, "Ah yes, but my patient looks wonderful." And they did, you know, and Y couldn't say anything because she was right, you know, so what, she'd get time to clean up her bed area but her patient did, they were clean, they were comfortable, they were happy, but they're the important things, yeah its little things like that happening that are important. (2:7,15-31)

Acceptable excuses for an uncomfortable looking patient included time and emergencies. Even though *I like[d] to have the patient looking fresh and clean and comfortable for the next shift to take over. This [was] not always possible when the patient [was] a new admission or very sick, and I [was] happy that nursing is a 24 hour job so you [could] hand over a mess.* (Nbview.doc:2,32-35)

A comfortable looking patient gave us satisfaction, however, these patients were usually in the unit in order to recover.

Sometimes recovery and comfort could not coexist

From time to time there was tension between our role to provide comfort and the ultimate aim of recovery for these patients. Again, our connection with these patients helped us determine which goal was more important at this time.

Toni acknowledged the need for ICU nurses to prioritise recovery compared to hospice/oncology nurses, because we mainly have people in the critical phase, its different pain management than people with sort of like a terminal illness when you tend to be a bit more liberal with the medications and things, and you tend not to have so many hesitations to increasing things and giving more just so that they are comfortable. (6:3,29-35) Bryce explained that he aimed for a comfort level that was satisfactory for us so as not to affect them in any sort of physical way, but yes satisfactory for them. (4:8,34-36).

We thought it was our job, we wanted these patients to feel it, so we did what we could for comfort.

Attempt caused outcome; the use of available treatment options caused uncertain comfort and pain levels

Although at times we caused discomfort or pain in the course of our nursing activities, we used a range of available measures to promote comfort or relieve pain in these patients. What we used again depended on our experience and knowledge, which in turn resulted in variations of treatment. However, whatever method we employed, or to whatever degree, we remained uncertain of these patients' experiences of comfort and pain while under our care.

Attempt; the use of available treatment options_

In addition to medications, which were under medical control, we cared for the physical, and to some extent, emotional comfort of these patients through basic nursing care.

There were times when we justified the need for these patients to experience some pain. Medical and nursing responsibilities within comfort
Doctors controlled medications which nurses administered. Nurses chose from a range of other comfort promoting options.

Asha clearly differentiated medical and nursing responsibility You know, of course when you talk about pharmacological treatment that's a medical thing. Certainly we're the advocates and we can bring it to their attention, but as I was saying earlier, there's other things I think that we can do from a comfort point of view (2:15,11-16) **Bryce agreed**, OK, we've quelled the physical pain, but we want we want this person to feel comfortable as well cause there's that thing, if I was in physical pain, you could put me in a position where I was uncomfortable too. So, you got to try and get that person its like a big fork isn't it, a two pronged fork, you've got to try and pick both things in one hit. (4:11,19-26)

Narcotic analgesia and sedation

Our knowledge of the pharmacology of narcotic analgesia and sedation was formally taught to us as well as experienced via previous patients. We based our administration decisions on this varying knowledge. Although we seemed to have a degree of flexibility with the written orders, doctors maintained reasonably tight control through the use of verbal directions during rounds.

In our unit, morphine was the usual narcotic analgesia given to these patients. Petra thought we tend to use morphine because its easy to titrate and can go in an infusion and is cheap as opposed to sort of fentanyl or anything else. (10:3,20-23)

Morphine for headache told by Patrick

there was a case the other day and we still tend to try and say, even if they've just got a headache like from the operation still give 1 mg of morphine. *What was the one the other day?* Oh, it was a crani, an aneurism that they didn't end up getting, and she was fairly much awake and ready to go to ward, and she... had a headache and one mg of morphine and sort of went st'.. *Normally, on the ward they might get panadol Panadeine Forte, yeah, or panadol...* I thought, "Oh, isn't there something else we could give here like," and I thought, "Oh, panadeine forte," and I thought, "Oh, do we have any panadeine forte on the ward?" I had to check whether we've even got it you know... it is narrow-minded, its a routine of the thing... its not an excuse its just an explanation, I think we need to sort of continually try and sort of be a little bit more creative , which is not encouraged from the medical side again, either. (5:17,5-30)

However, we wondered whether other narcotics and analgesics would be better in some circumstances, *I was actually talking to one of residents [doctors] on nights about why do we just use morphine all the time, because somebody had pancreatitis was changed from pethidine to morphine infusion because they were agitated on pethidine. They said, "It wasn't working." But, you know how they shouldn't have morphine [because it causes spasm in the sphincter of Oddi], and I said, "Well, there's heaps of other narcotics, why aren't we using omnopon, fentanyl and whatever else?" And she said, "I don't know." but, and then she said, "It's good and bad because everybody knows morphine, everybody knows the dose of morphine, everybody knows what's a big dose and what's a little dose of morphine, whereas all the other narcotics are different sizes so they're mg or mcg or something. But that's pretty slack, you can learn that. (5:17,31-18,13) I also heard that somewhere in another hospital they're using omnopon for chest pain because it doesn't cause so much nausea, you know, I mean, morphine causes nausea so people with chest pain, its not very good to be wanting to vomit. So, yeah, I mean, we should really find out about other things that are available. It is a medical decision but.. (5:18,16-22)* **Rhea drew on her previous experiences to suggests some alternative analgesics** I mean we don't have omnopon at all. We don't even stock it. I mean, I don't know why, its just gone out of vogue or they just, maybe there are problems with metabolism I don't know. Another one

that they never use well there is Toradol which came out on the market about four years ago, three years ago... its oral plus its IM [intramuscular]... I don't know, if they can give it IV [intravenously] or not. But if you consider our long term patients why can't we give them a regular IM, its a non non-st.. *A non-steroidal* yeah an anti-inflammatory and it works quite like morphine and pethidine and I used to use it where I last worked. I know to begin with, when it first came on the market there were problems with bleeding but that has since, you know, not been a problem, and I don't know if they even use it [here] ... It seems to be that they did not tend to consider new drugs on the market, not that there's a lot to compete on a regular basis but morphine and pethidine and stuff but there's nothing in between. (8:14,25-15,14) **Bryce volunteered that alternative narcotics and analgesics should be considered, but choices based on research,** I guess alternative uses of things as well... do we specifically need to use morphine for every case, I mean, excluding those that are allergic to morphine, perhaps... pethidine may have been linked to a better management of, I don't know this but say abdominal surgery say the better manager of abdominal surgery whereas morphine is better for orthopaedic or visa versa. So OK, we might use pethidine in orthopaedic patients because the majority of studies have proved that, like Panadeine Forte is better for skeletal like bone pain (4:23,14-26) **My theoretical learning has taught me that some analgesia is better than others for different types of nociception, eg, panadol is supposed to be more effective than morphine for bone pain, however, I have not seen concrete examples of this in practice. In our unit, the director doesn't like the nurses giving panadol because it is metabolised in the liver and can cause the patient's LFT's [liver function tests] to rise.** (Nbview.doc:1,42-47) **Rhea thought** we should be ones that do a lot of research and a lot of trials of different drugs because we are a big teaching hospital, and you know, we're a big unit we should be more into it, but I'm telling you (8:15,28-32) **Patrick guessed** it could be nursing initiated, the fact that we could say, "Well, in the incidences where this is not appropriate, or where we could use something else." then we could have another protocol on standby, so we don't sort of go willy-nilly with anything, but we say "Well, you know, this is another option for us." Because I think [the medical director] is very much, he's very much ABCD, you know and so if G is not in the options then you know, you just don't use G, I mean, he's got his point, I mean there's some very good reasons for doing that, but I think there comes a point when we say "Well, maybe we should look at G." (5:18,23-19,2)

I thought narcotic analgesia was the first choice and most potent comfort measure because I believe it is quick and effective (based on education and seeing its effect in awake patients, no personal experience). I would try to get an infusion of morphine ordered (steady dose for patient and less work for me going to DD [dangerous drugs] cupboard frequently). (Nbview.doc:1,23-26) **Patrick assumed** those people... will always have a, like a morphine and midazolam infusion up anyway (5:2,8-9) **Petra thought** generally patients that are paralysed or acute anyway their pain seems to be quite well managed, well from like a medical order side, and then its up to the individual nurse to fulfil the order (10:5,9-12) **It was the individual nurses that created variations in treatment.**

Bryce was clear when it came to the aim of analgesia, you've got to get rid of pain there and then its not a matter of saying "Let's wait and see.", because that doesn't do any good for the for the patient, so you've got to get rid of it then and not later, because the idea of pain management is to manage that pain adequately, its not, "Oh, let's wait and see.", that's not managing, that's... torturing someone (4:17,28-36) **However, Leticia was unsure of the exact level of analgesia needed** the difficulty with that is at the time you suction someone they might have abdominal pain because they've had surgery and yet in between times they don't move and their completely comfortable, so do you titrate their infusion for the time that they're

being treated or do you aim your management at in-between times (1:3,22-28) **Leticia resolved this dilemma by aiming to keep her patient comfortable** rather than completely pain free (1:3,18-19) I think I tend give them a general level of comfort that they appear to be almost pain free (1:3,32-33) try and minimise the pain for them during the procedures (1:4,1-2) **Robyne was unsure where to aim her care because she was unsure where the patient was at** you don't want to oversedate them, you know, you don't want them to be there in pain, so, you know, its a bit hard to know when exactly, you know, what's too much, what's too less when you not getting any feedback. (3:1,31-35)

Hesitation in giving narcotic analgesia seemed to stem from a lack of pharmacological knowledge. We thought giving too much narcotic analgesia stressed the body to metabolise it, lowered these patients' level of consciousness and possibly caused addiction. Other hesitations were more soundly based; respirations decreased and vasodilatation caused a drop in blood pressure.

Sometimes we were guided by a vague notion that too much narcotic analgesia was bad. Beth noticed that some people are really reluctant to give it (7:5,17) Bryce thought there's always that notion sitting in the back of our minds that we're going to give too much, and I guess we sort of lag back and then and we don't give enough then (4:6,27-30) Patrick remembered occasions in an intensive care setting... where I've given far too much, and, you know, more experienced people come sort of after me and they sort of say, "The pupils are a bit small here. Maybe we should turn this down from ten maybe to five at this point," (5:8,11-16) Rhea asked can you justify continually giving someone a narcotic on long term basis because he should have pain? ...Well, I don't know, well I mean, I, yeah, it's a fine line isn't it? (8:13,16-21)

At other times we had more concrete concerns. Patrick thought the only time I would just sort of wean it off my own accord is if like blood pressure was too low or we're going to extubate the patient and so I felt that you know, we'd try and get them to breathe up a little bit more and I just felt that we could probably achieve the same with a little bit less, and just sort of not sort of challenge them too much, not metabolise too much of the stuff because I mean, I guess one thing we don't sort of consider either is... and I think that there's probably a lot more research again needs to be going into that as well (5:16,25-17,1) Leticia thought once you do the course you have a greater medical knowledge and knowing the consequences with people's haemodynamic status like if they're a bit hypotensive that you may not give them such a great bolus of morph and midaz, or you might give them morphine and then give them the midazolam a bit later on or vice versa, 'cause having experienced people losing blood pressures and things like that because you give them both at once or whatever so, yeah seeing things like that happen you think, "Oh my gosh, I've got to get this patient's blood pressure back up from 50, sort of thing teaches you not to do that as well or to think twice about doing it and look at their condition as a whole picture and not just oh, they're in pain, but looking at it in the context of where they've come from, like whether they've just come back from theatre and they're hypertensive and so by giving them you're going to treat their blood pressure as well, or if they've just had a massive haemorrhage you know you want to keep them pain free as well, that sort of thing (1:7,29-8,10) But Beth didn't consider hypotension an adequate reason for limiting analgesia the other problem I suppose is when they are hypotensive, people are often very reluctant... and I often find that a bit hard. (7:8,13-17)

Will it bomb her out? told by Taylor

a lady who had oesophagus, you know, that would be very painful, suctioning that, I mean I was giving four boluses an hour to her, and still having an infusion going, and... I'd think "Oh, god have I given her too many boluses for that hour? Will it all accumulate, and bomb her out all at once?" I'd think like that too, but I'd think, "Oh well no, 'cause she's still... in obvious pain." (9:21,10-18)

Patrick thought are we getting people a little bit addicted as well whilst they're in hospital? (5:17,1-3)

Long term use and withdrawals told by Rhea

they[the doctors] tried to wake[the patient], withdraw morphine and midaz and stuff like that because of long term use to wake him up no, because of long term use and withdrawals. You know when they've [the patient] been on it maybe two or three months and they do get like the tremor and stuff. And they[the doctors] say that, they put that down to withdrawal, ...his tremor, although he had it pre op, but we didn't see, his friends and family said he did have a bit of tremor, but his was really noticeable and they were putting it down to withdrawal. But it would have to be a combination of morphine and midaz. (8:11,8-14,27-31) It's not that they[the doctors] were not trying to give it, like they sort of come to the conclusion that its time to stop. Its not, "Don't ever give it because of.." you know, its just they get to this point, you know its time we should consider stopping. *Because they have the tremor and then they stop. Do they have the tremor after they stop?* No, they've tried to wean or tried to wake them slowly and I've noticed that they put this bit of agitation down to, ...But they get to that sort of, to you know, think about six weeks, and you sort of look and, "Oh god, they've been on this for a long long time" and consider reducing it (8:12,1-10,20-25)

On the other hand, some of us thought there was no problem with being generous with narcotic analgesia. Toni believed its probably not going to hurt them one way or another, so you're probably better off to give it rather than not give it. (6:14,2-4) Patrick observed we tend to give them a little bit, probably a little bit too much pain relief, just to make sure they're getting enough, rather than being on the other side, and I think that's quite a good thing, because at the time it doesn't really matter to them whether they're too, you know, drowsy, or it doesn't sort of influence their sort of recovery at that point in time. So I think that, although we have our pain chart and we sort of try and titrate our pain control to level two, [mild pain on procedures] but I think a lot of the time its sort of at around level one [no pain on procedures] and I think that that's quite good (5:2,10-21)

Technology and other support for these patients in ICU allowed us to deal with side effects of respiratory depression and hypotension in most cases. Leticia knew they are fully ventilated anyway and they may stop breathing but its not going to compromise their lives (1:7,3-5) Asha also thought an ICU patient is the safest patient you can have, especially if they're tubed, they've got a tube down their throat, they're not going to stop breathing, you know, if they do, its very easy to look after, anything that happens to them you're going to pick up early, you know, I think you're safer than a ward situation some of the time, because you've always got a doctor there, you've got skilled nursing staff at some stage (2:2,1-7)

Bryce thought some people are sort of blasé about it and they go, "What the hell, he'll be right, he's ventilated, he'll be fine.", which I guess, when you think about it, is good and is bad, I mean, people think yeah, "Respiratory depression, OK that's the primary sort of side effect." (4:14,17-22) Taylor found that's hard when being inexperienced and knowing oh, you know, how are you going to do this procedure now and you know, if they're on four like that head guy that's on four infusions and knowing what to titrate and if you haven't done a course or something, you know, you're not that experienced, its quite scary. I'm just looking up at the monitors, you know, "What's happening?" And you know I have only had one year's general experience all up and its just a whole new learning experience for me and a little bit scary and anyway.. Like, you know, drugs that drop someone's blood pressure or... and especially when they're also with morphine infusion you just, you know. But its all, I mean, its all one big learning game I suppose (9:18,2-17)

Once again our pharmacological knowledge, together with pathophysiology, expected path of recovery and responses of previous patients, as well as those observed in these patients, determined our administration of narcotic analgesia to these patients.

We looked at the patient's body size. Leticia thought, well, he's a bigger man he'll need more pain relief (1:13,31-32) Rhea reasoned if its a big person we start off at a higher rate than we than we would for somebody smaller and that has been going on for a long time, somebody's bound to have hit it right somewhere along the way (8:7,16-20) Petra usually start[ed] with the baseline of what you'd think for their weight and probably add[ed] a little bit more to that anyway, and then if they're reacting to, if they're having changes in their blood pressure and their pulse when you're touching them or moving them or anything then you give them a bit more.(10:2,9-15)

We looked at tissue damage. Robyne linked physical causes of pain to analgesic dose, when I'm working with someone who's paralysed, if they're a head injury patient, they're on at least about 3 or 4 mls of morphine an hour via an infusion, that's like, if it was 2, I'd be thinking, "Oh, maybe that's not enough, you know, oh, don't know about that." If its multiple fractures and stuff like that, I'd be more edging toward the five. And those times when they are lighter and they're not paralysed and you're doing things with them you can see sort of where you're at, you know, a little bit. (3:8, 12-22) **Bryce thought patients with similar tissue damage would need similar amounts of analgesia.** ...*if you had two triple A's [abdominal aortic aneurysm] do you think they would have about the same amount of morphine?* Quite similar, yeah, I think, in relative comparison, in say in terms of mgs per kg of body mass or something like that, ...the staff are generally sort of like yep that's acceptable amount to give that person and they now appear to be quite settled and pain free, so *you still go on what they look like, that's really the bottom line* Yeah (4:22,7-17)

We accounted for things we did to these patients that caused pain. Patrick gave them a bit of morph before you do dressings like that. But then we don't sort of do that for turns and stuff like that. (5:15,23-25) *I would base the dose on patient size and injury and cues (grimacing, stiffening, sweating) and physiological parameters (BP, pulse). If I took over a patient, I would increase the infusion if the patient was exhibiting any of the above and the plan was to keep the patient comfortable, or I would decrease it if the patient didn't move at all and was completely floppy when turned, or temporarily for low BP (Treat the BP with something else because I do not believe pain should be a treatment for hypotension, I have seen this)... I would give boluses of narcotic analgesia from the infusion before turning and before dressings if the patient exhibited signs of increased pain at these times and not at other times but I would prefer to have a steady rate all the time to prevent the possibility of me forgetting to give a bolus and feeling bad for the patient because I have caused pain unnecessarily or causing the patient to drop BP at the time of the bolus. (Nbview.doc:1,26-40) I think turning to change the sheet (along side sitting up to take x-rays) is the most painful procedure for these patients and is when they would exhibit the most signs of pain and when I would be most likely to give them a bolus. (Nbview.doc:2,35-38) Rhea went a step further and gave analgesia for comfort rather than just to relieve pain, I think its important that we realise comfort as well as what you perceive as pain. Physical pain, surgical or whatever, discomfort is going to be just as bad and its going to nag just as much as like a physical pain inside, you know or whatever and we've got to remember that, you know, the tubes just can be as annoying, it won't be because of physical pain but because they're there annoying all the time. Its going to be just as bad as pain and that would be justification for giving them something for comfort (8:26,30-27,2) Leticia thought of all the things that you do, like suctioning, sort of the easiest and you just go and do it. You know*

that that causes them distress and yet that's always when they want to get the tube out and move around, like you can do most other things to someone and they tolerate it but suctioning is something that's just horrible, and you just go, "Oh, a bit of a cough coming up now.", and ram this tube down their other tube (1:10,11-18)

Bryce remembered similar but awake patients he has nursed to give him a baseline for administering analgesia, then he titrated the dose to any indications from this patient, you look at how you other people have reacted, "OK this person's got similar injuries whether it be from an operation or whether it be from a sustained accident and so, right OK, the last guy that I gave this amount to he went overboard, maybe I'll just cut that back and go from say half that, and that fits if he's feeling good, then I can give him an a little bit just every now and then to keep him over that." ... So, yeah, you sort of get them to a peak I think, and if you think that peak is verging over the top, then you slacken off a bit and wait till you've sort of come back down a little bit and then start to keep them at the top again or you keep pushing that little bit more to try and get to the desired effect. (4:9,27-10,3)

But Bryce was aware of the possibility of actually causing discomfort with the narcotics aimed at relieving pain, but there's nausea as well, I mean, there's this person sitting there and can't move and literally trying to wretch their guts up... I mean, when you think about it we give morph and midazolam, how many times on the ward... have you given someone just 5 mgs of IV morph to quell a bit of pain, and they've gone, "I feel sick now," and thrown their guts up. But we don't give any maxalon or anything like that regularly... OK there's side effects again from each of those drugs, like maxalon, but that could be one thing that is enough to help that person through, because, OK its provided the pain relief, OK my broken leg's feeling quite good now, but shit I'm feeling pretty crook, I mean, its like that two prong pronged fork that you said before yeah it is definitely you've caused discomfort yeah its a catch twenty-two, you've corrected one but you've caused... is there any contra indication as to why we can't put, I mean say, what we've got 100mgs in a hundred of morphine, why we can't say put 20 mgs. maxalon in there to try and..? (4:14,22-15,9) why can't we say give it even sixth to eighth hourly, sort of, just a TDS [**three times a day**] dose, help them through because, I mean, OK they might be really feeling quite nauseous underneath all that so, and do.. I mean, that raises a question, "OK, is the person wriggling around because they're agitated, they're in pain or are they sick on the stomach?" And we go, "Oh, they're in pain." and give them another bolus just to help them along and we put them out, I mean. So what have we done? (4:15,20-30)

We gave narcotic analgesia and sedation as a priority when these patients first arrived in the unit because they were unlikely to have reasonable levels in their body and we wanted to minimise the negative effects of the stress response caused by anxiety and pain.

Settling in a new admission told by Patrick, Robyne, and Beth

Patrick looked after a patient from theatres and you know, blood pressure sky high and you sort of immediately go “Oh sublingual adalat or SNP[sodium nitroprusside]infusion,” and then they sort of, “Ah ah, just sort of give them some morphine and some midazolam and that’ll be fine.” And you just go, “Okay, I’ll do that,” Oh, it really works. (5:8,29-34) Robyne usually organised analgesia early, morphine, midazolam, someone’s always had it at some point in their admission and its always sort of the first, I think, you know, twenty minutes that’s dealt with. Whether that’s to, you know, just to settle them in a little bit. (3:9,17-21) I mean its always the first thing when they come back from theatre, partially because you don’t want them waking up really quickly and going berserk, and their blood pressure getting out of control, and all that type of thing. You know, quite often it’s just because they are in pain that all those things are happening, so you just try and resolve that and get that step out of the way and then see if maybe the blood pressure is due to something else (3:5,17-25) **Because of her length of experience, Beth thought** so often when they come back from theatre and they’re not responding but they’re very hypertensive I find that a lot of the anaesthetic registrars will immediately say, “Morph, Midazolam” its just a way of settling them down too and they’re obviously, you know, the patient’s obviously in pain although they haven’t been reversed and... sometimes I’m even tempted to even have it there ready because you know what’s going to happen (7:7,19-29) its hopeless trying even to ventilate them sometimes because.. So its better to get that the analgesia part sorted out first. And then, there’s you know the danger of hypertension depending on what sort of patient it is, unless you sort it out quickly, they can rebleed, carotids blowing (7:8,27-9,1)

Sedation was often put together with narcotic analgesia as a treatment package. Morphine and midazolam were usually administered together in a single infusion which caused us to often view them as a unit. Beth found especially on night duty that you can give them lots of sedation and analgesia early in the night while they’re fully ventilated and then wean it off, but some people don’t, its a give it very lightly and then the patient’s really distressed by the morning and then things go wrong (7:9,12-17)

However, we considered sedation useful in causing patients to be hopefully unaware or forget, especially when these patients were pharmacologically paralysed. Toni remembered stories of people intra-op who, you know, the anaesthetics haven’t worked and they’ve been fully alert during the procedure but they’ve been unable to move or talk or do anything, you know, and that would just be terrible, oh I couldn’t think of anything worse.(6:21,17-23)

Awake in theatre told by Rhea

I actually looked after a man when I, in my first ICU job, who had gone to theatre for the third time and was paralysed and not sedated or analgesed, because it was a rush back to theatre, they hadn’t the time, so... he woke up and he was writing on the piece of paper, “I was awake, I was awake”, and I nearly died, but he was he was actually a friend of my family and knew my father, and I met him since then, and he didn’t want to do anything about it because basically they’d saved his life and he walked out of hospital, but he said it was the most frightening experience in his life and he said he was mentally shouting you know “Its sore, its sore, stop, stop.” and couldn’t do anything, so like I’ve always remembered that and there’s no way you would never not sedate somebody. (8:8,19-35)

Asha found at other places I’ve worked just [had] to remind medical staff to perhaps give some sort of amnesic agent as well. I guess that comes more into comfort than pain, but though, like you say, its difficult to separate the two. (2:12,29-33) We connected midazolam with amnesia, but we were not clear of the pharmacology of this. I thought if they’ve had midazolam, they’re not going to remember that short term bit around where they’ve had the midazolam. (5:22,3-5) Whereas Petra thought the patients that do come back and sort of see you before they go, especially a lot of the head injuries and that sort of thing remember absolutely nothing of the whole situation. I mean that’s probably a combination of the midazolam as well as just sort of the whole experience. ‘Cause, the way I understand it, midazolam doesn’t just knock off your memory like for five minutes while its working but it has a sort of effect where it stops your short term memory of things that have happened sort of in the last hour or so as well (10:8,7-17) We thought it was good for these patients to forget their ICU experience, Leticia considered it better for them to be oversedated and analgesed I think... I mean I guess if someone comes back and says they can’t remember it

that's a good thing, rather than, "I remember all this pain." (1:16,37-17,4) **However, I wondered about the effect of their experiences at the time, if you don't remember a week later what you've gone through, does that mean that you didn't go through it? At the time it could have been really horrible and then because you've been given midazolam you don't remember, which is good for them, I think, its good for them not to remember but I think that they shouldn't have had to have experienced it in the first place, unless it was necessary, you know what I mean** (5:22,8-17) **Patrick asked** Which means that if you can't remember, do you conceptualise pain? (5:22,6-7)

An added benefit of sedation was to make our job easier; sedated patients were easier to ventilate and they lay still. Leticia said, yes it makes a difference when this patient has midazolam, I can keep them in the bed and they will ventilate and that sort of thing (1:7,8-10) **Patrick knew** sometimes we give them a bit of the midaz too. I guess it just sort of makes it a little bit easier for us as well... I can sort of think of instances where you sort of say, "I'll just give this patient some midazolam so he can get some sleep," but I think also you're very relieved when once they are asleep. (5:11,1-8) I've known people to criticise that thinking and like over a period of a shift it can have its positive aspects as well... If you look at the whole say, ten hours, especially if you think of night shift, I think its a big impact on what happens in the morning, you know. (5:11,17-22) I think we're fairly human in that. (5:11,27) *You don't have to be so watchful I suppose, or so next to be bed, or if they're going to injure themselves. Yeah, or watch their hands Yeah, so I suppose well that's got lots of issues in it and its got comfort issues as well as safety and giving the nurse a break.* (5:11,10-15)

Further learning on pharmacology and patient response would have possibly improved our practice. Leticia thought lots of education around the place is a good thing... we're taught about what the drugs do and how they work, but we're not really taught how to use them, I don't think. (1:4,29-33) maybe education in those sorts of things is where it would be more helpful rather than how to use the drug, a bit more about how to expect the patient to respond or something. (1:13,35-14,1) **However, our knowledge on patient response was empirically based.** Leticia asked, oh how could you teach someone? Cause I guess in a way its so experientially based, like you need to see, and a patient on one mg of morphine might be almost unconscious and somebody else on five mg might be climbing out of the bed, so you can't say, "Start your infusions at two mls and hour and increase them, you know, in hourly increments of one ml." and that sort of thing, to be that rigid isn't really possible either. (1:5,4-11)

Some of us thought that alternate routes of analgesia would have caused some of these patients to be more awake. Toni thought of femoral blocks for legs and those sorts of things... there's lots of ways you can give pain relief without necessarily just having, you know, morphine drip running (6:8,7-11) **she also considered** epidurals are quite good for pain relief for sort of like triple A's and things, 'cause you can sort of get them up and mobilise them quite quickly... We don't use them enough, I don't think. I know that some of our doctors don't like them very much, but I've seen them used quite a bit, and especially with triple A's and other sorts of big abdominal surgery and things, lots of gynae and things, they use epidurals... So when you're weaning them and things to get them extubated early the next morning, first day post op, they'll actually, you know, breathe up better... they can actually get up and walk around, whereas, often if they're on morph and midaz they're a bit bombed out. They don't tend to sort of respond as quickly. (6:2,32-3,24)

We used narcotic analgesia and sedation for these patients according to our connection with these patients and our knowledge and experience of the drugs. However, on certain occasions these options were restricted or not available to us.

In the interest of recovery, narcotic analgesia and sedation were limited

When the doctors wanted to wean ventilation in a view to extubate these patients, assess neurological status accurately, or these patients had liver or renal failure, narcotic analgesia and sedation was often decreased or stopped.

The most frequent occasion narcotic analgesia and sedation was withdrawn or limited was when these patients were weaned from mechanical ventilation ready for extubation. Robyne thought it was better for these patients to put up with a little pain in order to be extubated I have a tendency not to give it, because I figure, if they can just put up with a little bit of pain for now, and get that tube out, that'll be a lot better for them. Unless its obviously that that's really bad and if its really bad they're probably not going to be well enough to extubate anyway, because there's obviously something else happening. (3:12,6-11) Whereas Asha preferred to treat the pain if you can't wean the ventilation because you've got to give too much morphine cause they're in pain, so be it, that's why we have ICU's, you know. (2:14,1-4)

Others of these patients suffering neurological injury received less analgesia because their neurological status needed to be assessed. Robyne had a problem with the neuro cases because quite often they'll say, "I want all sedation ceased so that we can reassess them." And I know that's necessary, but, you know, that's a compromise they're waking up, they're gonna maybe be in pain, but we have to assess their neurological status. (3:9,22-27) Taylor remembered the morning orders were not to give them any anything, no pain relief, you know, just to see what they're doing, which I suppose they've got to do, I suppose to see neurologically how much damage that there is but I mean that probably wouldn't be comfortable for the patient. (9:16,11-17) Rhea thought where they're [doctors] trying to assess patients that you find it really frustrating that they possibly.. we see it as agitation but that could be pain and they don't want us to give them anything and that's the hard point, we know what's happening, what can we give them? You know sometimes its better not to give them something that's really important, but we know agitation could not necessarily just not be cerebral irritation, it could be severe pain and that's one thing that's hard to deal with. (8:3,10-20)

Neuro headache told by Taylor

someone was extubated, ...they were OK and were going up to the ward but they were saying, "Are you OK?" "Oh no, I've had this constant headache the whole time." "And did you have it before you were extubated?" "Yeah, yeah, yeah" you know, but they couldn't.. you know, its just so hard to communicate and you know you can deal with it when they're speaking, you know that they've got a headache. (9:16,29-17,2)

Several of us noted that neurological assessment was a priority over analgesia for other injured parts of the body. Toni thought at times, you sort of tend to focus more on the neuro part and, you know, try not to give them lots of pain relief and things, because you want to see whether they're alert and orientated, whereas, you know, they've got multiples fractures, obviously they'll be in pain. (6:4,20-24) Asha said, we used to get a lot of traumatic head injuries, you know, kids in car accidents and things like that, all sorts of things, and they'd want to wake them up after twelve hours or something and they'd be cerebrally irritated, thrashing around the bed, and oftentimes I remember saying, "This kid's in pain, you know, we've got to give him something." "No, no, no, we can't give him anything." And I felt that they were in pain because even though they were cerebrally irritated, well I guess, a part of it that I felt they were in pain was because they had

broken legs or something as well... because they were a head injury, even though they've just had a stinking great rod put down their femur, you know, and their foot's been crushed and they've got facial fractures, because we used to get all horrible things like that, they weren't to be given any morphine, because they wanted to see what they did because they had a headache and they'd, as I said, they'd be thrashing around the bed, but oh boy, they must've been in pain, as well. You know, you just must if you've got a fractured leg, and as I say, if these people were in the orthopaedic ward and quite *compos mentis* they'd be given a regular four-hourly narcotic. (2:14,19-15,5)

Patients with liver or renal failure were not adequately clearing analgesic drugs, so often analgesia was limited with these patients. We had vague notions of the reasoning behind it. In liver failure we thought the liver would be further stressed. Bryce thought, "OK if you're liver's shot," you think well "OK what are we going to do about that?" OK you don't want to start throwing drugs there that the liver's going to try and break down and excrete it. (4:19,32-35) **Patrick guessed** you sort of see sort of you're challenging the liver to metabolise more and I guess the same I don't know, then if its in failure then it's going to make it in worse failure well, maybe at this point, what's left of the liver we need to save for, you know, if we've got to give drugs like digoxin or, you know, the old antibiotic sort of treatment and stuff, (5:14,28-35) **Rhea didn't** know where morphine and the metabolites go with liver failure, are they just going to the body, you know to accumulate (8:13,28-30) **I said** *some people have indicated to me that that there's this sort of weigh up between if you give too much then you're stressing the liver which is already in failure and I don't know whether that's true or not. I'll have to find out.* (7:6,20-23) **In renal failure we thought morphine or its metabolites were not cleared from the body. Toni** thought it would hang around for a long time (6:14,13-15) **Rhea said** that's why, you know, the guys want to stop it after a long time of use and things, especially with renal failure I know that its definitely built up in the body, I'm almost positive its morphine that they don't excrete, which means its hanging around which means that when you do try to waken them up and get them breathing, but try and keep them.. you can't find that fine line between pain control and like totally knocked off because of their you know urea and creatinine have gone off (8:13,35-14,6) **Petra explained** B brings this up in his lectures, actually, I can't remember it exactly, but basically, patients with like an overwhelming type of sepsis, I think it was, can get that quite agitated look about them but its not that they're particularly in pain... its more a response to their actual septic state and because they've got liver problems, and they've got renal problems, instead of being able to excrete it **[morphine]** they're accumulating it and getting sort of more toxic by it and the more you give them the worse they actually get. So I mean, I don't really dispute that. (10:6,29-7,7) usually, they're not quite so restrictive with, like if they've got big dressings and what not, they'll let you give something for dressings, but its to try and avoid this, you know, every five minutes because they look uncomfortable in the bed. And its like CAL **[chronic airways limitation]** patients where you say, you know, they look terrible, their breathing's not good but they always look terrible and its sort of similar with these types of patients where they're always going to look agitated until they can detox type of thing (10:7,17-28)

Patrick explained his reaction to this situation, when their creatinine and urea just their renal function goes off, just sort of switch those sort of things **[analgesia and sedation]** off. What do you think about that? Its a strange thing, because you're sort of thinking, "Oh god, you know, I should be giving some sort of pain relief here.", and again I think its sort of this thing that you've got none of your normal indicators that somebody's in pain that you just, I mean, it sort of seems that it slips into the background a little bit, sometimes you even sort of forget the fact that you know that he's not on morphine or midazolam infusion and I guess

sometimes when you're sort of at the beginning of the shift, and you're sort of looking through all the infusions, you go "Oh!" you know, "Should I sort of give them a bit of a bolus?" But, to me, its a little bit easier because you sort of know that physiologically it would be detrimental, would further sort of, you know, put them backwards if you did have them on a morph and midaz infusion and give them pain control. (5:6,29-7,15)

When he turned he grimaced told by Nerilee

this guy had a big abdo wound dressing and there was no analgesia written at all and he was this type of patient who was unresponsive and lying there and they [the doctors] were saying things like the metabolites of morphine will still be around in his body so he'll still be analgesed and... it was really a dichotomy with him because when you did the dressing there was nothing, no response at all, but when you turned him he grimaced... later, they wrote up an order for, to give a bolus before dressings and it was really when he was turned that he grimaced so... I found that hard and I find that those sort of things have happened over my time, you know a few times.(9:11,2-19) But I was thinking it would be interesting you know, if he gets out of here to see what he remembers. Because so many of them are like that, they have multi-organ failure, or something, and don't get any analgesia for a while, don't live, so you don't know, sort of what they're living through. (6:14,28-34)

Leticia's story showed the doctor's control of narcotics and sedation, especially their limitation in the context of weaning ventilation and liver disease, how the doctors discounted Leticia's view of this lady's experience, Leticia's lack of exploration into other comfort measures, and how she used distancing to cope with nursing this lady in pain while teaching a new nurse.

She had Malaena and Haematemesis told by Leticia

She had been on a sedation infusion of about two mls an hour, very small lady, and she had been unrousable on that, or very lightly rousable, she'd open her eyes, just, and that was it, and seemed very comfortable, and they [the doctors] stopped her infusion to wean her ventilation and she was continually grimacing and when I discussed that with the doctors they said, "Well we don't want to put her back on the morphine infusion because she'll go back to sleep and she has advance liver disease so can't give her panadol, you know", we just couldn't give her anything and I felt really uncomfortable with that, and I was precepting a new nurse and I said to her, "I find it really difficult because I want the patient to be comfortable and I feel in a way embarrassed by asking because I knew she had advanced liver disease but I hadn't really thought the whole process through before I asked the question, I just knew that my patient seemed to be in pain, and so I said, "Well what can I give her?" and he [the doctor] said, "Well you tell me what you can give her.", so then I had to think about all those things and he said, "I don't have an answer, I can't give her anything", so, we couldn't and we just had to watch her grimace when we turned her. He felt that she was fairly encephalopic, you know, a bit under anyway, (laugh) so it wasn't going to be that much of a problem, but I still felt uncomfortable and I felt difficult about being with a new nurse who I was trying to teach to be the patient's advocate and recognise when they were in pain. I sort of said, "Well, sometimes you just have to ask the question and be told no, but at least you've asked the question." So, whether or not they do that after, you don't know. (1:5,20-6,13)

In specific circumstances narcotic analgesia and sedation was limited in order to promote recovery in these patients. This lead to the question of how much pain was reasonable to expect these patients to endure, both from a physical and psychological point of view.

How much pain was justified?

We wanted these patients to get better, and we knew that keeping them completely comfortable with the available drugs would retard their recovery, yet we were also aware of the detrimental effects of pain.

Often it was not possible to have a painfree, recovering patient. Patrick guessed you're biggest concern in intensive care when they're sort of really critically ill is their medical side of things, and I think to me that sort of needs to take precedent because, I don't know, sort of they go off so quickly (5:10,5-10) "Do you want to be painfree, or do you want to be dead?" I mean, "Do you want to have pain or do you want to be dead?" ... I think its through that its easier I think for some to justify that someone is in a little bit of pain, like if as long as that's not for a prolonged period of time, like normally turning or and as soon as we've turned him they

can settle down I think. That you sort of justify the fact that they're in a bit of pain, yeah. (5:10,16-26) I thought when... *the plan was to wake the patient - then I have to walk the fine line of less comfort and more consciousness* (Nbvew.doc:1,33-34) *its a weigh up thing. If you make them painfree then they're not going to be as well physically.* (5:10,28-30)

However, we wanted to also minimise the harmful effects of the body's stress response to pain. Bryce thought it was hard, I mean you can see.. OK you want this person to get better and the less that their body's got to try and put up against the better, fair enough, but, is their body going to get any better being in pain? A lot of pain? (4:19,17-21)

Even though we wanted to avoid the negative consequences of the stress response from pain, comfort for these patients was restricted at times. We even inflicted pain in the course of our work.

Coping with inflicting pain

We not only incidentally inflicted pain in the course of normal positioning and turning and other nursing activities, but actually intended to inflict pain when assessing for conscious level in neurologically injured patients.

Because we were unsure of the length of time neurological patients were unstable in their brain function, Patrick thought about the need to inflict pain on these patients and at what point they are no longer critical. I guess the only other issue that a lot of us, I guess occasionally we look at it... neuro assessment of people who are really deeply unconscious, are very deeply sedated because of their injury and... also you're doing neuro-obs because of their injury and I sometimes wonder what it must feel to have that sort of deep pain sort of instilled... is it is it necessary to do that, would it be enough to have a look at the pupils every hour? Because I mean, do you really need to know whether somebody's moving their right hand every hour? I guess, I don't know whether, would you stop moving your hand first before you blow a pupil, I don't know? *Are you talking about the type of patient that's like ICP[intracranial pressure] monitored and on Lignocaine and sedation?* Yeah, but I think there's also another sort of group which where they're sort of like not doing much and, you know, they're been with us for a while and sort of like, you know, the old needle comes out and you know *ahhh* Aw, (laugh) and I wonder whether that's particularly necessary. I think its necessary to do it a few times a day. *Sometimes they've changed it to once a shift or on the doctor's rounds but that's generally later isn't it?* Yeah a lot later in a sort of very safe period, I guess the argument again is, what's the precedent? Is the physiological precedent or I don't know? *So instead of being are you dead or are you comfortable,* (Laugh) *its are you dead or will we inflict pain on you to make sure you're not dead?* (Laugh) That's right. (5:24,25-25,25)

Especially for those patients whose analgesia and sedation was limited, we had to cope with inflicting pain when we changed their position in bed, gave hygiene care, or attended to their dressings. Patrick and I spoke of the importance of justification for the pain *I wonder how we cope with all this torture that we do, but that's another study. It's all for a reason, that's why. Yeah. I think that's why I think you justify it through that. Yeah, the reason's pretty important.* (5:25,28-26,3) **Leticia coped by reassuring herself**, well I've done all I can do, now I've just got to turn her, and look the other way, you know, or hope its not too painful or try and reassure her or something, and reassurance, you know, its like suctioning doesn't do anything, really, it doesn't stop the pain, doesn't fix it (1:13,7-11) **Patrick tried to do other things** like your turn is very gentle and you assess whether he really does need a sheet change

now because I mean a sheet change sort of tends to be more, you know, sort of really, really painful and stuff so, you try and do other things to I guess combat a little bit better, you know, when they're not getting any pain relief, from that aspect. (5:7,15-22)

We coped with inflicting pain, whether it was through intention or not, by focusing on the benefits of our actions rather than the pain these patients felt. On the other hand, when there was no benefit to the patient because they were dying, we focused completely on comfort.

Dying patients were kept comfortable

We believed that the very process of dying was painful. We usually gave analgesia liberally because the tension between comfort and recovery was eliminated; we did not want dying patients to experience any discomfort. However, we then confronted a tension between comfort and killing.

Not wanting these patients to feel pain or even be aware, we were generous with analgesia and sedation. Beth thought in that situation I most probably would give quite a bit. Just in case. (7:4,16-17) Yeah, most are a real comfort issue (7:4,25) Petra had a rule of thumb I think you've just got to sort of pick a reasonable number and double it and add one, because basically, you're not going to do them any harm if you give them too much, its still going to be the same end, but you're going to do them a lot of harm if you don't; if you under control their pain. So I always turn in that situation, and tend to go for the more is better. (10:6,12-20) However, Beth considered its just to make us feel better too, that you end up giving that morphine, although some people are reluctant to give it. They say "Why am I giving this 'cause I can't see [any indication of pain] (7:4,29-32)

Ample analgesia for dying patients told by Robyne

Essentially, they[the doctors] said, this guy was requiring so much adrenalin they'd pulled out and he didn't have any family, but that's a whole another issue. O.K. you don't have any family, forget it, so they said, "Well we're ceasing treatment." So I turned the ventilator off,[allowing spontaneous breathing] I turned it[oxygen concentration] down to 30%, his saturations were, you know, about 40, turned all the stuff off and I gave him[an amount] morphine in half an hour and he was dead in about ten minutes. And I had no qualms about doing that at all. I know that dose probably killed him, but he would have lingered longer if I hadn't have done that. (3:7,5-15) I mean, in that instance I wasn't going on his grimacing, I was thinking how awful it would feel for you to be conscious and knowing that you were about to die, and I didn't want him to experience any pain whatsoever in that time, and that's why I did that. And it was so hard to tell whether was experiencing 'cause he wasn't doing anything. You know, it was like, "You gonna die, I'm not gonna let this pain, you know, linger, make it longer."(3:7,18-28) I mean, situation on the ward too, I remember a lady who, you know, she was dying of cancer, and she was basically scoring about three on the Glasgow Coma Scale, and she had a KVO[keep vein open] drip up, and she was alive for about two days just getting the regular doses of morphine that she would be, and, I mean, that's a tragedy... I would have loved to have intercepted and given them more, but I wasn't in a position to do that. When I was in a position to do that, I did it. (3:7,31-8,7)

Because we believed dying was painful, we thought all dying patients needed analgesia. Sometimes it was necessary to remind the doctors of this.

Asking for a bit of dignity told by Taylor

there was another lady, I think it always happens to like those.. she was like a bag women, she was in ITU, obviously a street women but hadn't, you know, kept herself very well and it was like the doctors didn't care as much about her as the other patients, like they knew she was dying and she was NFR[not for resuscitation] but like they didn't write up pain relief for her in her last and I remember one of us had to go and ask the doctor's to write her up something, 'cause she was NFR but she was lying there, just deteriorating, just rotting away and had no pain relief and like every other patient had it. I just found that a bit, you know, I think that those type of physical, social stuff come in to how the doctors treat people. I think it does in a way, you know, social aspects and that sort of stuff. 'Cause we had to go and ask for her to have pain relief and a bit of dignity while she died. So, and that was in our unit too. (9:14,31-15,14) I mean the doctors shouldn't have, they should treat everyone as equal patients, I know it doesn't happen you can see it (9:15,20-23) they were just the ones that swap around [resident medical officers] but they should have written up pain relief for her, just to die comfortably, she was dying anyway. (9:15,28-31)

When giving generous amounts of analgesia and sedation, we were not sure at which point providing comfort turned to killing. Rhea thought its hard to know where that fine line is to where you're giving that push and they stop breathing. I rely heavily on the doctors to tell me that you know, this is sufficient and its not the lethal dose 'cause, I mean, I know ethically its hard for people to deal with, you're giving someone something I mean, and I strongly believe it has to be given to keep patients comfortable. They may not be experiencing pain, but there's a certainly mental anguish and things like that (8:20,4-13) **Asha also avoided hastening death as long as the patient looked comfortable**, there is a fine line between what you perceive to be enough to take away their comfort and what is too much but I think there is also a point where it's obvious that you've overcome their comfort problem. You know that they are comfortable they're, you know, solminent. (2:13,9-14)

Comfortable but alive told by Asha

I had that man in bed one and his wife helped me wash him at the end of the night Yeah and they were, just on the evening shift, pouring morphine into him and that man was barely conscious. He was comfortable, you know, but he was alive. (2:13,14-20)

Patients who were struggling to breathe exhibited more distress while dying and we thus had reason to be generous with analgesia and sedation.

He was distressed told by Toni

we decided on my shift that they were going to withdraw treatment and put him on trachy mask and things, and we just kept giving him heaps and heaps of morphine and things and lots of midazolam. So I think he was quite comfortable and the orders were quite liberal, as to what we wanted, and I had no hesitations in giving him, you know, frequent doses, 'cause he'd got put on the trachy mask, he started getting quite distressed and you could tell he was just distressed and, you know, uncomfortable. So I had no hesitations and the medical staff were quite happy to keep sort of, you know, giving as much as we thought. So that was quite good. That was managed reasonably well, but you could tell he was uncomfortable struggling to breathe and his resps rate was up like around the 50 mark, and he was really sort of shaking a bit, grimacing and you could tell he was just, you know, getting very distressed and uncomfortable, 'cause he got really tachycardiac (6:17,8-31)

The 16 year old boy with leukaemia told by Rhea

his lungs were really shot and they tried the nitric oxide on him for a long time and eventually decided you know, that it wasn't going to cure anything and the mask [thick and tight] was really irritating him and so they spoke to the family. Up to this he wasn't getting morphine because he was getting the support of the CPAP [continuous positive airway pressure], and they decided just to let him to let him go and we explained to him and he was quite prepared that we would give him something to keep him comfortable because he was frightened. So like the mental anguish of him, you know, sort of terrified of, you know, was he going to be gasping for breath, we said, "No, we will give you the oxygen, we'll just going to take that big thick mask off so you can talk to your mum and dad." That was good, I thought it was well thought out and there wasn't a question about it. The doctor came up and said this is, you know, "we're going to give him some morphine and keep him.." We were giving him relatively small doses but enough to keep him comfortable and as often as we felt it was necessary. You can imagine that it came to that I mean, I know I don't know where that line is, where you're giving that dose and the next thing they're asleep (8:20,15-21,1)

When we knew that dying patients were not going to recover, we were generous in our administration of analgesia and sedation, some of us wanting to hasten death while

others just wanted to provide comfort. In any of these patients, dying or recovering, there were options, other than drugs, which we used to promote comfort.

Selected nursing comfort care options

Even though we emphasised narcotic analgesia and sedation in our comfort care, there were other options available to us. We positioned these patients in bed and frequently changed their position, kept them clean, touched them and talked to them. Which options were chosen depended on our connection with these patients, our knowledge of physiology, what we had seen work before and what we imagined to be beneficial, in conjunction with routines of the unit and time available to us.

I wondered why we didn't use a wider scope of comfort promoting activities, *I don't know, whether its we're really busy most of the time, we often grab the morphine or the panadol or whatever analgesics and we do our routine things like positioning them, but there's so many other things that you could do for comfort. Do you know what I mean? Like that that I don't think we think of. We either, to me anyway, I'd probably prefer to sit down ah, do you know what I mean? Like, instead of rubbing their feet or doing all those things* (8:23,27-35) Rhea had seen positive results in awake patients but was unsure of the benefit for these unresponsive patients, the smallest little thing totally non-nursing related can make such a big difference, but in our situation I don't know if its relevant.(8:25,33-36) I was not aware of research into the efficacy of different comfort options for these patients, *there's no connection, there's nobody that's said, "Because I've had this abdo surgery and it hurts and you've given me morphine and its made it a bit better but if you rub my feet it would be heaps better,"*(8:24,23-26)

We spent most of our shift doing many activities for these patients. Leticia suggested better timing of nursing care could have aided their comfort, sometimes I think that I'm not so good at concentrating my activities to a certain, like trying to concentrate them at one point in the hour, instead of taking the whole hour to do all these things and continually going back to the patient and disturbing them (1:4,4-8)

We positioned these patients in bed. Rhea thought position would have to be the most important because they can't tell me and that's something we can see and do something about. (8:2,23-25) So she looked while we're positioning the patient well obviously we look at, does it look comfortable to start? Or in alignment? Which is the normal position for limbs and things like that and we're always pretty good about supporting with pillows and using extra blankets and things like that, checking to see that they're not lying on parts of the equipment and stuff . You sort of picture yourself in that position you know, if you were lying in the bed in a position that looked uncomfortable, you know, would you lie like that when you're trying to sleep? (8:2,1-12) *I position[ed] the patient in a way that look[ed] comfortable to me, taking into consideration their tissue injury, eg not lying on incisions or drains or pieces of ICU equipment.* (Nbview.doc:2,8-10) Patrick made sure that their head [was], sort of, in a comfortable position, sort of not like screwed with their neck, that their back [was] nice and aligned so they [didn't] sort of get too much back pain from those awful mattresses. Also, you know, a pillow between their knees (5:3,5-9) fluff up the pillows (5:24,9) and Rhea pull[ed] that pillow round a wee bit more just to support under the neck. (8:29,33-35) *I usually turn[ed] the pillow over and pull[ed] it down to their shoulder and put the tubes, lines, drains etc into some sort of order and not tight.* (Nbview.doc:2,22-24) Even though we thought these patients looked comfortable, Patrick had some insight into the real comfort of our standard positions, I was talking to someone the

other day and they sort of went to bed themselves and sort of positioned themselves as a patient, the way we position our patients, and they sort of said that that wasn't really all that comfortable. (5:2,26-30)

We considered what the patient was lying on, having a choice to add a softer mattress to the top of the standard ICU mattress. *I would try to get a [type of pressure relieving] mattress if the patient is thin or already has pressure areas.* (Nbview.doc:2,10,11) **Patrick questioned the comfort of either mattress**, from reports of people being on those mattresses for any length of time, they're sort of not the most comfortable, which.. I don't know, I guess we're trying to get better.. but I guess those [soft] mattresses, although they're good for the skin, I'm not quite sure whether they're too good for the back, because, I mean, they sag and sort of, you know, sort of fold up underneath you and have lumps here and there...Certainly nothing like the medicos bed that you know that one with the different cells, that sort of blows up (5:3,30-37,4,10-12)

We frequently changed these patients position. I cited the physiological reason *The routine in the unit is to turn the patient from side to side second hourly and only on their backs for washes and doctor's rounds. I generally follow this because leaving a patient [not turning them second hourly] might allow them more rest and less pain temporarily, but disrupted skin integrity or lung pathology would cause greater problems later. This type of patient is completely in my control, so I have to be aware of all their body parts and attachments when they are moved.* (Nbview.doc:2,11-18) **Whereas Patrick thought of comfort**, the difficulty of this is that everybody has that most, sort of, comfortable sleeping positions and you just can't communicate that with them at that time, so you just sort of assume that, you know, by sort of switching them over every couple of hours, at one point you'll have them in a comfortable position for at least two hours (5:3,10-15) **Bryce wasn't so sure that probability would overcome individuality**, we think yeah, sure, we're making them comfortable rolling them from side to side, but does that person really sleep on side to side, they might sleep on their stomach and just solely their back (4:3,22-25)

Because of its frequency and routine nature, at times it was easy for us to minimise the impact of changing these patients' position. Patrick thought it was because of the lack of response from the patient I guess you try not to, but I think that if your patient is conscious and the eyes are open I think you tend to turn a little bit more, I don't know, to try and be just that degree more gentle, because you can actually sort of, you know, visualise that, you can sort of see the pain, whereas, I guess, with the very unconscious, you sort of, think 'cause they sort of, aren't able to show their pain... I don't know. Sometimes I sort of notice that when you get help with turns and stuff on nights...sort of, the old heave ho! (5:6,8-20) **I thought knowledge levels might contribute**, *usually the wardsperson helps turn patients (or more if the patient is very large), and it is an issue that some wardspeople are rougher than others...* (Nbview.doc:2,18-21) **Asha's story highlighted the different importance of people's time in a hospital setting and how the needs of the patient seem to come last.**

Turning in a hurry told by Asha

I remember turning someone and the wardspeople were in a hurry, it was like the wardspeople came up from the wards, and they were in a hurry, so we turned my patient and my trachy tube nearly came out, 'cause I was in a hurry and I didn't communicate with the patient, and the patient was trying to tell me that something was wrong, and I didn't listen to the patient, I was too worried about getting this patient just turned, again its a task thing. I had to turn the patient and that was that... I think we get harassed by other people too, we all do and we do it to people I'm sure, everybody does it, you know when they're trying to turn someone and the patient's just coughing and gagging, sputum's pouring up the tube and, you know, you often say, "Let's stop, suction the patient and we'll go on then." and, you know, the wardy or whatever says, "No, come on, come on, I've just got to do this." or x-ray says, "Look, can we just take this x-ray?" and, you know, it takes a bit, I guess its age as well, you know, a bit of maturity and confidence to say, "No, I'm going to suction the patient." and, you know, there's times where you've had to do, where I've had to do that and that's the big thing that we're patient advocates. (2:6,2-11,16-29)

We cleaned these patients thinking of what it was like to be clean ourselves. Patrick thought having their mouth cleaned very often. I think that's a very sort of big part of being comfortable. Having that awful taste out of your mouth, whether they could sort of realise that at the time or not (5:3,17-21) **I agreed** *often I suction the mouth after every tube suction, but clean it with mouthwash second to fourth hourly and do a proper scrub with toothbrush and paste when I wash the patient.* (Nbview:2,26-28) **Patrick also considered**, like the eyes, you know, not sort of clagged up all the time, I think that's a big part of comfort. (5:3,23-24) *Their eyes could need hourly to fourth hourly washing with saline and drops or ointment.* (Nbview:2,28-29) **Patrick continued**, like just wiping someone's forehead or head just with a, with a sort of like a warm damp cloth every so often I think that does a lot for them. (5:3,24-27) *Depending on how sweaty they are, I may have a wet cloth hanging by the bed to wipe their face and forehead whenever I walk by the bed.* (Nbview:2,29-31) **Once a day these patients received a complete bed bath.** *At the end of my shift, I wash the patient.* (Nbview:2,31-32) **Patrick thought extras we could add to the wash would help these patients be more comfortable** I guess that's another comfort issue is the wash in the morning (5:11,28-30) I think sometimes its a little bit forgotten as well just little things like shaves and hair washing and stuff, I don't think that's done enough either. (5:12,3-6) I think that's probably very difficult to sort of visualise for like say, female nurses, but like a shave in the morning, is just like, its beautiful, you know. You'd feel like, you feel alive again, and its nothing like getting out of the shower and having a good shave and, so its like there'd be no way I wouldn't shave somebody in the morning, like, I mean, unless you know given its like you can't sort of expose them or something because its too cold or something its one of my sort of things is a guy's got to have a shave (5:11,30-12,3) **I knew what it was like to have clean hair** *Imagine what you'd feel like if you had your hair washed, I mean even though they're in bed and its not like having a shower, but at least you'd feel slightly more clean.* (5:12,8-11) **Rhea's story showed how she thought things that she had experienced herself while a patient could help these patients.**

Foot wash told by Rhea

I know what I've done on numerous occasions is get a basin of water on the bed and put people's feet in it because when I was in hospital the sheets were all tight around my feet and it was driving me nuts when I had the pain and it was this was driving me nuts and I'd said to the nurse, "Would you mind, no matter what you do to straighten the sheets around the bottom of my feet" and she stood and washed my feet and she literally put the basin on the bed and soaked. And I've done it for other surgical patients who are on bed rest and stuff, to them its just heaven... its got nothing to do with their tummy pain and whatever, but in our particular situation they're more acute (8:25,10-24)

We treated minor skin and mucous membrane irritations. Asha found you often come along and find people with raging oral thrush or peri thrush and nobody's thought to order nystatin, pretty easy thing to do, easy to get rid of, or even excoriation, you know, when people have got bad diarrhoea just getting some zinc or doing something just to protect them a bit (2:10,20-26)

We used various levels of touch with these patients. Patrick, imagining himself as a patient, thought sometimes you sort of try and give them a bit of a back rub and that sort of thing (5:3,29-30) or like being at the hairdresser, sort of you're lying back and your head's sort of .. and give you a nice massage, very nice. (5:12,14-16) Whereas Asha's stories showed how she had seen touch successfully used to promote sleep.

Sleep inducing massage told by Asha

she got heart lung transplants, her lungs were stuffed, and she got a shocking heart. It was kept alive on adrenalin so she was never going to live and she was with us for so long, she went into renal failure, liver failure, just everything, total body failure basically, and she never used to sleep. She used to lie wide awake at night, we had her on massive amounts of diprivan of a night to try to get her to sleep and I remember one night I got some oil or something and was giving her a foot and calf massage and she fell fast asleep. And I thought, god, you know, like it took a bit of time I guess and effort but it was something good to do (2:16,3-14)

Reflexology told by Asha

he's the sickest person I've seen live. Amazing that he did. He was on like 100% [oxygen] for three weeks. He's amazing, but his sister used to come in every day and do, what do you call it when they rub their feet? *Like reflexology* Yeah, reflexology on him, yeah. A friend at work told her that it might work and so she had this little map of a foot, she'd say, "What's wrong with him today?" and we'd say, "His liver's off a bit." and she'd rub his liver section, but she sat for hours rubbing his feet and that's when he fell asleep. (2:16,15-25)

However, because these patients were unable to give us feedback on the effect of touch and we were not aware of physiological benefits, those of us who had no personal or empirical evidence were unsure of value of touch. Rhea felt doing a bit of massage and just a back rub, I'm tempted to say that sometimes its not practical... because of maybe certain conditions and position and stuff like that, but also if they can't tell us, there's absolutely no way, what's the point in rubbing their feet, is that going to solve their headache, you know, or sore ribs, their sore tummy? We don't know where their pain is, I mean, we can say, maybe sort of say, "OK, right they've got a head injury, sore head." you know, they've got a flail chest, OK, (...) when they're taking deep breaths, but in what case would you sit and rub their feet? I mean, like I can understand and I would spend hours and I know yes, I'd rather sit down too, but like Gillian Barré you know, they can't tell you, and you know that they're sore and they're stiff and the greatest relief to them is if you stood all night and rubbed their hands and feet and just did passive movements with them, and I have done that for them, but I can't.. *Because there's no connection there's nobody that's said, "Because I've had this abdo surgery and it hurts and you've given me morphine and its made it a bit better but if you rub my feet it would be heaps better."* Yeah there's nobody that's said that so that you.. or the likes of, I mean I know a lot of people whose beds are damn hard and if you rolled them over and rubbed the small of their back I'm sure they'd just be in heaven but is it going is it going to stop the surgical pain that they have or the headache that they have or... I don't know if its of benefit... I would say I wouldn't be, I wouldn't go gung-ho about it,(8:24,2-25,10) **Maybe the usefulness of touch had more to do with our skill**, I'm sure if you were in one of the Asian countries they would say, look, do a body massage as you're having your bed bath to an unconscious patient, would be you know, so much beneficial to them and relaxing and all the rest,(8:26,1-5)

Some of us thought of other options related to these patients' senses. Bryce suggested if we do get someone who's say of an alternate lifestyle, OK morphine may be good, but is a bit of aromatherapy and a bit of say their friends talking to them even if this person can't communicate back, is general chat and relaxation tapes going to be of benefit as 2 mg of IV morphine? (4:11,12-17) **Rhea had more knowledge of aromatherapy**, I'm all for getting scents, you know, essential oils and stuff, in the unit 'cause I think you know, the ones that calm the senses and stuff like that would just be so beneficial, especially for the sleep deprivation, (8:26,5-10)

We talked to these patients to prepare them for the impact of our nursing activities.

Nobody warned her told by Asha

My friend was actually in a very bad car accident when she was younger and she was in an ICU, and she remembers a certain level of consciousness, and I think this is important to know too, and I always think its a pity our patients don't come back and give us feedback on their time in ICU, but she said she was still having sleep/wake cycles, though obviously nobody noticed, sort of, you know, she must have still had her eyes closed or whatever. And she said she remembered one time waking up with this excruciating feeling in her hand, and it was enough to open her eyes and they were doing, I don't know, a stab for blood gases or putting in an IV or something, some sort of needle in her hand. She said nobody'd tried to wake her and tell her, nobody warned her it was coming, they just did it, and she said it was a terrible feeling, and then she remembers a commotion afterwards so she must have put up her blood pressure or something... Many times when I've orientated new staff to ICU, and you know, when you're teaching them to do things like suction or, blood gases, we used to do our own blood gas stabs, give injections, all sorts of things, and saying to new staff, "Now tell the patient what you're going to do." (2:8,5-28)

However, we tended to minimise the impact of the more frequent or routine activities.

Leticia thought about suctioning, sort of the easiest and you just go and do it, you know that causes them distress and that's always when they want to get the tube out and move around, like you can do most other things to someone and they tolerate it but suctioning is something that's just horrible, and you just go, "Oh, a bit of a cough coming up now.", and ram this tube down their other tube (1:10,11-18) **Bryce considered the endotracheal tube** I think there's more discomfort than pain associated with that than... we realise. I guess the majority of staff haven't had a tube or something put down their throat that's a half inch in diameter to see what it feels like, so, yeah, can we really sort of like say, "It's all right, you relax." (4:5,22-28) **Patrick compared what he said to what he saw**, its like "Oh, look, I'm just doing your dressing here," and its like and your abdomen is right open, you know (5:7,27-29)

We reflected on our diversity and contemplated how we had become and how we could impart our knowledge. **Bryce thought** people've all got different ideas on how some pain should or shouldn't be managed (4:23,30-32) **I didn't think** *new nurses to ICU can be taught "how to" other than to make them aware of what to look out for and what options for comfort are available.* (Nbview.doc:3,12-13) **I learnt when** *I watched other nurses and asked lots of questions. I think that non-analgesic methods of promoting comfort came from watching role models, whereas, the use of morphine was learnt more by asking questions. "What do you think?" type questions.* (Nbview.doc:3,4-7) **Rhea thought** The information gathering is from experience definitely... nobody can teach that, (8:5,1-4) **We thought improvement would come through increased mindfulness.** **Leticia thought** there weren't definite answers, but maybe its an awareness thing for the staff (1:5,11-13)

As nurses we were able to do a range of activities other than giving drugs to provide comfort. We chose these activities based on our connection with these patients, our experience and knowledge, and the environment in which we worked.

Outcome; uncertain comfort and pain levels

Whatever options we had used to promote comfort and treat pain in these patients were based on what we knew and how we connected with them, so our care varied. We were not privy to immediate feedback from these patients in order to evaluate our care, instead we had to live with not knowing for sure what their experience was while under our care.

Because they were not responding, we were unsure and found it difficult to know for certain if these patients were comfortable or not. Petra felt if they're not capable of purposeful actions its very difficult (10:3,35-36) Bryce thought if you can get some feedback it's good, but its very difficult on the upper half, on our side to try and interpret that pain... when you can't get feedback (4:3,1-5) it's a difficult area because you can't get a person's verbal responses often (4:7,13-14) Toni agreed, its very difficult to ascertain whether they're actually in pain or not. (6:1,25-26) really sometimes you can't also see that much either. You know, like if you've got them sort of heavily sedated or.. with lots of morph and things, I mean, you're not sure (6:2,23-26) Rhea said its hard to know. (8:16,2-3) I'm not a hundred percent sure to be honest (8:6,15) you don't know, I think it is pretty hit and miss. (8:7,12-13) I was *not sure of their comfort. I based* my care on an educated guess. (Nbvlew.doc:1,6-7)

The effect of the care we gave was also unknown. Toni reflected the uncertainty I think at times you do tend to think, "Well, you know obviously they're in pain so I'll give them this." Whereas you don't really know, and its hard for you to know, its really sort of catch 22, if you don't give them something, they probably in pain, but if you do, whether they need it or not is another thing. (6:13,29-34) *I'm still not confident of my comfort/pain management skills, because there is no indication from the patient that I have done a good job in this area. I do my best and hope that is good enough for the patient.* (Nbvlew.doc:3,7-10) Rhea did all I know what to do, and I can't say its a hundred percent right (8:6,24-25) its a very difficult thing to actually do. Who knows what's right and who knows what's wrong. (8:30,21-23) I hope we're doing our best (8:30,27)

As a result of not knowing and our diversity as nurses, the care these patients received varied. *I think its more up to each nurse who's looking after them and that nurse is, I guess guessing... in a way, for their shift and whatever's in that nurse's head and experience will apply to the patient for that shift and it will change for the next shift. That's what I think is happening at the moment.* (3:14,30-36)

Because we were unsure of the outcome and based on our differences as nurses, we gave varying comfort and pain care to these patients. Variety rather than uniformity featured in the care these patients received, however, we did not know any of the effects on their experience.

Action	too hard/don't know what to do/not important → give up feel responsible → try
Goal	to provide comfort, was individual and depended on belief that good nurses provided comfort or all patients deserved comfort, or tasks needed to be completed or recovery was a priority.
Attempt	those chosen depended on what treatment options nurses connected with (theoretical knowledge and experience) <ul style="list-style-type: none"> • pharmacology and previous experience of narcotic analgesia and sedation • priority of recovery - know pathophysiology of patient - limit drugs for analgesia and sedation sometimes • ?what amount of pain is reasonable to experience in ICU? • necessity of inflicting pain - minimising to cope • Is dying painful - what is killing? • comfort impact of position/turning, hygiene, touch, talk - based on imagining, previous patients, physiology
Outcome	hard to know what patients are experiencing; they may look comfortable but are they? or they may look in pain and we are unable to eliminate that look - we have to cope with that. Minimising because of poor connection with patient.
Discussion	connection relies on experience and knowledge (unqualified belief that doctors / expert pain teams have greater experience and knowledge - discounts our own connection to this individual patient) increase education on <ul style="list-style-type: none"> • physiology • pharmacology • efficacy of treatment options for different pathophysiologies increase experience vicariously by consuming and doing research all this will increase awareness of comfort in a 'saving-life' environment nurses still want clarity - objective assessment tool! Therefore nurse via evidence based practice

This is a four episode story

The full version is in Appendix W.

Setting	
Episode 1	
Beginning event	assigned to care of non-purposive patient
Simple reaction 1(a)	seeing tasks
Goal 1(a)	complete tasks
Attempt 1(a)	do tasks
(but) Outcome	(complication not caused by attempt) see patient through relative's eyes
Simple reaction 1(b)	important nursing role to provide comfort
Goal 1(b)	find out if the patient is comfortable
Goal Path	Attempt - can only use your's and others' eyes causes outcome - educated guess
Attempts 1(b) (all these attempts take time)	<ul style="list-style-type: none"> • assume awareness • assume pain or discomfort • age • gender • culture • 'hospitalised' or 'institutionalised'

	<ul style="list-style-type: none"> • physical signs • grimacing • body language • clammy • pupils • nociception • acute or chronic • individuality • relatives
(but) Outcome	clean and presentable patient for relatives to see
Attempts 1(b) (continued)	<ul style="list-style-type: none"> • imagining self as patient • gut feelings • advice - looking through other's eyes
Outcome 1(a)	difficult, unsure, educated guess (but you can live with being unsure until you have to write it down) documentation
Outcome 1(b)	discredited
Episode 2	
Beginning event	patients' comfort is unknown
Simple reaction 2	believe patients should receive individualised quality care
Goal 2	provide comfort as best these nurses can
Goal Path	Attempt - do activities that promote comfort causes outcome - unsure of patients' comfort
Attempts 2	<ul style="list-style-type: none"> • narcotics (hesitant – addiction, liberal – ICU is safe, new admissions, body size of patient, what the nurse can see, advocate for analgesia)
Outcome	pain is dealt with
(but) Outcome	nausea - relieving pain causes discomfort
Attempts 2 (continued)	<ul style="list-style-type: none"> • routine comfort tasks (turning)
Outcome	minimising
(but) Outcome	complication of trache nearly dislodging
Attempts 2 (continued)	<ul style="list-style-type: none"> • routine care (positioning) • mattresses/ pillows • basic hygiene • massage / reflexology • aromatherapy • treat minor irritations • talk to these patients to prepare patient mentally for procedures • explain limitations to patient - work within limitations • minimising to reduce alarm • sedation for amnesia • sedation to make patients settle
Outcome	nurses are human and function better if not stressed by restless patient
(but) Outcome	complication of tension between comfort and life saving treatments
Simple reaction 3	take in the whole picture
Goal 3	balance comfort and life saving treatments
Goal Path	Attempt - work within limitations causes outcome - satisfied that patient is recovering, though uncomfortable
Attempts 3	<ul style="list-style-type: none"> • neuro assessment • weaning ventilation • liver and/or renal failure • recovering
(but) Outcome	unclear guidelines

Outcome	wondering about inflicting pain
Episode 3	
Beginning event	dying patient
Simple reaction	believe dying is painful
Goal	relieve pain
Goal Path	Attempt – liberal analgesia Causes outcome - death
Outcome	Unknown
Episode 4	
Beginning event	brainstorming session
Simple reaction	think its a worthwhile topic
Goal	contribute ideas
Goal path	Attempt - put forward suggestions causes outcome - increased awareness
Attempts 4	<ul style="list-style-type: none"> • education • bring patients back to talk about what they remember • effective assessment tool • use experts • pre-op patient visit • changes in nursing practice routines • alternatives • epidurals • experience as a nurse • doctors come around
Final event	We don't know for sure patients' pain

Appendix G

Flow diagrams - outlining the flow

An example of one of the analytical tools I used was a temporally ordered flow diagram for each interview, as referred to in sub-section 4.2.1.2 of the thesis.

Flow Diagram for Interview 5

(5/1/33) Difficult to assess

(5/1/35-40) These patients always have morph/midaz - we give too much (Level I instead of Level II)

assume pain → doesn't matter if they get too much in ICU
given too much so that the nurse can cope (5/7/10-15)

go on (1) BP

(2) Put yourself in their position (5/7/32-45) - guy shave
make them comfortable - everybody's comfort is different - do the
best you can (p2)

(3) Would like to see what patients remember (5/3/5-18) but
question the truth of it.

(4) plan for recovery (5/4/41-45) ← Medical side of things takes
precedence in ICU because patients are critically ill. (5/6/32-37)
in organ failure no morph/midaz → detrimental (also (5/9/25-30)

(5) automatic pilot (5/6/7-13) everyone gets morph(5/4/11/4-14)

(5/4/34-38) may go unnoticed - (5/4/9-19) compared to awake patients

↑
more gentle with them(5/5/38-48)

may be misdiagnosed (↑BP → SNP/morph (5/5/38-48)

↓

(5/5/16-19) this may lead to forgetting there's a person in the bed - not just a living
body

(5/8/24) relatives remind nurse or nurse sees patient through relative's eyes

(5/4/46-5/5/3) limits on analgesia → cope by nursing measures

worries→ are we getting the person addicted? (5/10/42)

→ are neuro obs necessary so often (5/16/1-25)

(5/1/28-31) Goal : to achieve comfort

(5/15/36-37) if met = good nurse.

Flow Diagram for Interview 6

(6/1/20-21) difficult to assess - ventilated, paralysed, sedated
(6/3/41-48) and (6/4/18-27) but advantage of time spent with patient over doctor's five minute assessment (page 4)

(6/1/22) overlooked - patient looks comfortable (6/2/1-4)
+ different perceptions of pain by nurses (6.1.26,27)

so go on

- (1) tachycardia and grimacing (6/1/32)
- (2) gut feeling (6/1/34-36)
- (3) what they've had done (6/14/6-39)
 - we might think its minor when its a big deal to them (6/14/26-29) story (6/14/48-6/15/20) and (6/15/34-6/15/41)
- (4) plan - have to balance recovery with pain relief (6/2/37-45) as opposed to oncology or terminal patients.
 - assessment story (6/3/1-15)
 - ventilate want them to breathe up (6/1/39-43)
- (5) putting yourself in their place (would they be in pain?) (6/4/6-9)

(6/5/1-28) Difficulty of having hands tied by doctor's orders - only so much you can do
(6/8/47-49) Nurse thinks patients in pain but doesn't really know (**ambiguity**)
if in doubt give analgesia (6/9/6-8)

story (6/7/24 - 6/8/12) of ideal nursing situation (↓ anxiety and ambiguity because she was sure patient wasn't in pain during painful nursing procedure.)

A contrast OR story (6/11/4-23)
IDEAL death → liberal morph

Appendix H

Nurses' metaphors - seeing the images

The nurses' metaphors that I searched for within transcripts were clustered under topic headings then used to create the original poem in Appendix X, as referred to in sub-section 4.2.3.2 of the thesis.

nurse imagining self as patient

putting them(nurse's ideas) onto them (patient)
put yourself in their shoes

visual images

whole picture
look the other way
slips into background
nothing stands out
eyes opened
pick up on it

activity

slicing open abdomen
palm it off
pumping analgesia and pain relief
covers your pain

violence

liver's shot
torturing / living torture
combat
fighting
knock off memory

target

hit and miss /hit it right/ way off

descriptions of patient in pain

climbing out of bed
leaping about the bed
screaming tachycardia
going berserk
as stiff as a book
throwing their guts up
gasping for breath
pain is going to nag

descriptions of too comfortable patient

encephalopic
a bit under
losing BP
make them into a contortionist
bombed out
spaced out

balance

over the cliff
get to the edge
edging towards 5 (mg/hr morph)
push her over the edge
top them up
get them to the peak
verging over the top
come back down a bit
catch 22
it's a fine line
happy little medium

administration of analgesia

upper half
other side
pussy footing
dangling a piece of cake
two pronged fork – pick both things with one hit

progress

down the lane
see someone coming along
help them along

ending treatment

pull out
linger

relationship with doctors

rocking the boat

learning

normal learning curve

religious

swear that this is gospel

eating

food for thought

miscellaneous

you can be hard

fashion

gone out of vogue

Appendix I

Analysis of an anecdote - *signifying the structure*

I analysed anecdotes for meaning using the narrative strategies of Labov, Gee and Mishler in a line and stanza format as referred to in sub-section 4.2.1.4 of the thesis.

1. I think the person I looked after who was very well managed	abstract (Labov)
2. was um,	
3. when I was working in intensive care in C with a burns patient.	orientation (Labov)
4. <i>(Ah ha)</i> (cough)	me showing shared understanding (Mishler)
5. 40 percent burns	orientation (Labov)
6. so we kept him,	↓
7. we didn't transfer him.	↑poetic contrast (Gee)
8. We probably should have,	↓
9. but we didn't.	↑poetic contrast (Gee)
10. It was mainly torso and face and things,	orientation (Labov)
11. <i>(Hm mm)</i>	me showing shared understanding (Mishler)
12. and he was still ventilated at this point in time,	orientation (Labov)
13. and when we used to do his burns dressings,	complicating action (Labov)
14. we had an anaesthetic ventilator,	complicating action (Labov)
15. so we used to give him an anaesthetic to do his dressings,	
16. <i>(Oh, right)</i>	me showing shared understanding (Mishler)
17. that was fantastic,	evaluation (Labov)
18. he would not flinch or move,	complicating action (Labov)
19. 'cause burns dressings,	
20. you know how traumatic <i>(Mm)</i> they are,	me showing shared understanding (Mishler)
21. was like a two hour ordeal,	
22. just transferring him into the bath and those sorts of things,	
23. and do really, <i>(Yeah)</i>	
24. full full thickness burns it was <i>(Yeah)</i>	orientation (Labov)
25. everywhere	*
26. and, um,	*
27. we were really,	*
28. you know,	*
29. when he first came in	* these lines sound disorganised - hesitant
30. we weren't very experienced with burns and things	the sound of the words reflect what it is like to be inexperienced (Gee)
31. and, um,	

32. it was just by chance that one of our registrars had worked in a burns unit somewhere else	orientation (Labov)
33. and said	
34. "Well, you know, I think we should do this"	complicating action (Labov)
35. and, ah..	
36. The first dressing,	complicating action (Labov)
37. the first time we did his dressing,	repetition for emphasis (Gee)
38. it was just after he came in from cas	*
39. and he came upstairs	*
40. and he was just on, you know, a morphine infusion or something	*
41. and he was..	*
42. you could tell he was just grimacing in heaps of pain	*
43. and those..	*
44. and no matter how many boluses were given it just wasn't effective.	* these lines are hurried and reflect how it was to nurse this patient - urgency but ending in distress for the nurse (Gee)
45. And we all got a bit distressed	evaluation (Labov)
46. 'cause you could tell that he was in heaps of pain (<i>Mm</i>))
47. and it wasn't working.) juxtaposed (Gee)
48. So we we got him reviewed and that	complicating action (Labov)
49. and we decided to get this anaesthetic ventilator,	complicating action (Labov)
50. oh, you know,	teller showing they know I shared understanding with them (Mishler)
51. you could put the (<i>Yeah</i>) whatever is on the side	complicating action (Labov)
52. (<i>the gas</i>) the gas	me showing shared understanding (Mishler)
53. and you could titrate to whatever we thought he needed,	complicating action (Labov)
54. (<i>ah ha</i>) you know,	
55. you just check,	
56. if if you go like this,	*
57. if he if he's	*
58. if you flicker	*
59. or twitch twitch	*
60. or anything	* short spurts of speech reflecting little hints can be seen and not much can be done to assess patient (Gee)
61. and you could just increase it and that	
62. and the anaesthetic reg used to stay there with us while we did it (<i>Oh right, yeah</i>)	complicating action (Labov)
63. and, um,	

64.that was great,	evaluation (Labov)
65.like you could do the dressings	complicating action (Labov)
66.and he'd be fine,	
67.then you'd put him back into his bed or the chair	complicating action (Labov)
68.and whatever you were doing	complicating action (Labov)
69.and it was really,	
70.it was really good.	evaluation (Labov) repeated for emphasis and similar to line 64 (Gee)
71. He was just,	resolution (Labov)
72. you could tell he was obviously in no pain,	
73.it was great. <i>(Mm)</i>	evaluation (Labov) repeated for emphasis using the same word as line 64 (Gee)
74. Yeah I thought that was very good. <i>(Yeah)</i>	evaluation (Labov) repeated for emphasis using the same word as line 70 (Gee)
75. Um, it was just lucky that they had this reg,	
76. 'cause we,	
77. I mean,	
78. 'cause there's lots of ways you can deal with burns,	coda (Labov)
79. and, you know,	
80. they can be on lots of different things and stuff	coda (Labov)
81. but just it wasn't really working, <i>(Mm)</i>	coda (Labov)
82. and so this was really good, I thought,	evaluation (Labov) repeated for emphasis using the same word as line 70 (Gee)
83. having the anaesthetic.	
84. <i>(Yeah)</i> Yeah,	
85. 'cause it was really short acting	
86. and we could do it for the two hours it took to do all his dressings	complicating action (Labov)
87. and, you know,	
88. the OT's and physios would come and do all their treatments and things	complicating action (Labov)
89. and he would be OK,	resolution (Labov)
90. you know, it was	
91. <i>(Yeah, get it all together)</i>	
92. Yeah, it was sort of all,	
93. it was quite good. <i>(Mm)</i>	evaluation (Labov) repeated for emphasis using the same word as line 70 (Gee)

(From Interview 6)

Appendix J

Writing under Labov's headings - *structuring the meaning*

An example of one of the analytical tools I used, approaching each nurse's interview as their personal narrative as described in sub-sections 4.2.1.5 and 4.2.2.1 of the thesis. In this instant using Interview 5 'Patrick', I wrote under Labov's headings of narrative structure.

Abstract

In response to the introduction of topic for discussion, Patrick indicates that issues of pain and comfort were emphasised during his nursing education, it was like the big issue (5,1,32) it was always like, the the big thing was it, always like, "Make sure that your patient is pain free, and and that he's comfortable, and or she's comfortable." (5,1,35-37) I wonder whether this is also an attempt to validate my research or give me a compliment. However, in the context of those patients who are incapable of purposive actions, Patrick describes the nurses' predicament, I think with this sort of patient that you're talking about, the ones that you just can't, that can't even grimace to sort of say that they're in pain and stuff like that, I think they're probably the most difficult to assess whether they're.. are they comfortable or in (Mm)in pain? (5,2,2-6)

The theme of difficulty in assessment of these patients' physical comfort and pain runs through Patrick's story. The skill of assessment is integral in nursing, not only to identify where the patient needs nursing intervention, but also to evaluate the effectiveness of that intervention. In this intensive care unit, many factors add to difficulty in assessment process, yet Patrick tells of the resources he uses to reduce this difficulty somewhat. A degree of difficulty remains, with which he must cope.

Orientation

Because Patrick and I are colleagues, as he tells me his story, he correctly assumes that I understand the context in which we both work. However, specific factors that impact on this defined area of nursing practice are mentioned.

Setting

Routines figure often in nurses' work, especially in the intensive care environment, it is narrow-minded, its its a routine of the thing, its just like which is not just its just an ex'.. its not an excuse its just an explanation, I think, (5,17,25-27) Patrick tells of the routine turning of patients every two hours you just sort of assume that, you know, by sort of switching them over every couple of hours, at one point you'll have them in a comfortable position for at least two hours (5,3,12-15) I think sort of you're limited to, um, um, our sort of really narrow sort of boundaries, as in patient left right on their side, you know, and bla bla this, and there's a handful of things we do and then, I think out of.. sometimes out of I think, time as I was saying, but also the fact that we also get locked in to this automatic pilot often (5,9,11-17)

Referring to the beds that critically ill patients lie on in intensive care, Patrick mentions the mattresses as a cause of discomfort, those awful mattresses (5,3,8) Um, from reports of people being on those mattresses for any length of time, they're sort of not the most comfortable, which.. I don't know, I guess we're trying to get better.. um, but I guess those spanco mattresses, um, although they're good for the skin, I'm not quite sure whether they're too good for the back, because, I mean, they sag (Yeah) and sort of, you know, sort of fold up underneath you and (Yeah) have lumps here and there and.. (5,3,30-37)

Other aspects of the intensive care setting are not overtly mentioned because of our shared understanding as colleagues.

Patient

Patrick clearly understands the type of patient towards which this study is directed. I think with this sort of patient that you're talking about, the ones that you just can't, that can't even grimace to sort of say that they're in pain and stuff like that (5,2,2-5) they're too, you know, (Mm) drowsy (5,2,15) I guess, with the with the very unconscious, you sort of, um, think 'cause they don't, sort of, aren't able to show their pain to.. I don't know. (5,6,14-16) **Not only are these patients unable to act in a purposive manner to indicate comfort levels, but they are critically ill, usually enduring invasive treatments aimed at aiding recovery.** I mean yeah OK you have sutures and then sort of the sutures inside of you and sort of like sort of sudden different pull in a different direction and (Yeah) and you've got these three drains inside of you and sort of you're turned and they scrape around in there. (5,15,32-16,2) they have huge dressings and stuff like that (5,15,20-21) , like she just had sort of the the tubes sort of coming (Yeah) out, (5,9,31-32)

Patrick is aware that these patients may remember their time in intensive care but is also insightful when explaining why nurses may not hear of their experience. It might be interesting to sort of, um, and I guess we never sort of all do that, where we sort of get patients who've we've had in for a long, or like for a reasonable amount of time and and talk.. get them.. (Mm) like talk to them about their experience in depth. I do know some of them come down and say, "Oh, thanks very much." But then.. (So, you haven't heard any patients come back and talk about anything in particular.) Um, (cough) oh, they've come back and they've talked about it and said, that you know, "Thanks very much and we got really good care here." Um, but I guess it would be interesting to to ask them specific questions about whether they were in severe pain at any stage and, um, did they feel pain, but were unable to com.. um, like communicate that they were in pain and and stuff like that. (Mm) (Cough) Whether they're at that time would be honest with you could be difficult to say, because it (Yeah) be pretty hard to walk into a place like that and say, "Oh, guys, (laugh) (laugh) you're doing it all wrong." (laugh) (laugh, yeah). (5,4,15-32)

Nurses

During his initial nursing education, Patrick was taught that an important nursing role was provision of comfort and management of pain, ever since sort of I did my training, it was like pain and comfort was always like sort of in the, it was like the big issue, (5,1,30-32) it was always like, the the big thing was it, always like, "Make sure that your patient is pain free, and and that he's comfortable, and or she's comfortable." And once you'd done that then you know you sort of reach sort of a certain level. (5,1,35-2,1) **Patrick extends this concept to say that patient comfort is actually a measure of the standard of nursing care,** I think its a very big issue in your training and I think that its very hard to its very hard for nurses to measure how effective they are and one of the, um, very few things that we can sort of have a direct measure of what sort of job we're doing is whether someone is in pain or out of pain, painfree, and I think that's why (Mm) we sort of like tend to sort of, um, make sure of that, you know. (5,23,24-30) It was just like, because any other things like you've just got so little control over like with blood pressure and stuff, there's no measure of whether whether you're doing a good job or not or whether the wound's healing or not, because that's not.. (Yeah) I mean, you can do things but you can never actually say, "Well, (that's because I did that) Yeah (laugh) because I put you on the zinc (laugh) and that's why your wound healed. (laugh) Um. (laugh,

yeah) so that's one of the very few things where you get a direct measure (*Yeah*) of how well you're performing (5,24,13-22)

After his formal nursing education, and while working in our intensive care unit as a new member of staff, Patrick absorbed the way nursing took place by observing those around him. I think you also tended to look at other, at how other people sort of do it as well. (*Mm*) and I think sort of that I've learned a lot of things of like, um, just sort of watching other people talk to their patients and and watching other people position their patients and stuff and and and ah, yeah, I think sometimes I probably could have been a bit more pro-active myself, you know, sort of sort of just watch somebody and think, "Oh, that's a great idea." you know, that's worked, (5,9,3-10)

Patrick is fully aware of the fact that intensive care nurses have other roles which can conflict with that of providing comfort and relieving pain, I guess you're biggest concern in intensive care when they're sort of really critically ill is um, their medical side of things, and I think to me that sort of needs to take precedent because um, I don't know, sort of they go off so quickly, that um, (*Yeah*) and so.. (*Is that because of the dichotomy between being dead or comfortable?*) Yeah (laugh) (*laugh*) that's right. "Do you want to be painfree, or do you want to be dead?" (laugh) (*laugh*) I mean, "Do you want to have pain or do you want to be dead?" (*Yeah*) Yeah, so I think that, and I think ah its, I think it's very easy to meet it, not very easy, but I think its through that its easier I think for some to justify, um, that someone is in a little bit of pain, like (*Mm*) if if um, as long as that's not for a prolonged period of time, is long that is is for like normally turning or or and as soon as we've turned him they can settle down I think. (*Mm*) That um, you sort of justify the fact that they're in a bit of pain, yeah. (5,10,7-26)

Doctors

Doctors enjoy a higher position than nurses in the intensive care unit hierarchy. Patrick conveys a feeling of intimidation or stifling, we could be a little bit more pro-active but then I think there's also, um, (4 sec pause) people are probably a little bit afraid of of what the reaction is from, um, (*B, laugh*) (Laugh), from the medical side (laugh) (*laugh*) (5,9,36-10,3) I think we need to sort of continually try and sort of be a little bit more um, creative (*Yeah*) which is not, which is not encouraged from the medical side again, either. (5,17,28-30)

When referring to a senior doctor, Patrick shows that he understands the rationale for this doctor's medical decisions but presents a strong case of poor attitude towards nursing staff, Because I think [medical director] is very much, he's very much um, ABCD, you now, you know (*Yeah*) and if and so if if G is not in the options then you know, you just don't use G (Laugh) (*laugh*) its not, you know. (*laugh*) which has, I mean, he's he's got his point, I mean there's some very good reasons for doing that (*Yeah*) but I think there comes a point when we say "Well, maybe we should look at G or not." (*In this case, for this person, (laugh)*) Yeah, and we're not, sort of, I think, well, how do you describe that? Um, what did he say at the ball, um, he doesn't, we don't need university educated we just sort of um, I think he said something like, "We don't need nurses with brains," or something. (*laugh*) not the likes of G and I think it was that night or the next night he was still fuming about that. (*Laugh*) saying that they don't need nurses with brains or something. (*Yeah, (laugh) I wonder, (ha) oh, its that's another topic, I just wonder whether he says all of that in jest to Mm (to get people cranky.) cough (Laugh) Ah yeah, he enjoys that too. (Yeah) (cough) (Yeah) He might have done that just to have a few females coming up to him and giving them a bit of a hard time. (Laugh) Hmhm.*) (5,18,29-

9,16) It is interesting that nurses can still respect or see the doctor's point of view even when treated poorly.

Complicating Action

Responsibility

Patrick comes to this particular nursing episode after being formally educated to take the responsibility for patients' comfort and pain. He also believes that his standard of nursing can be measured by the comfort level of the patients for whom he cares. I think we try really hard to to to make them comfortable (5,2,32-33) After admitting that these patients pose a problem in assessment, Patrick goes on to demonstrate how nurses take responsibility for their pain relief, those people who will be.. will always have a, like a morphine and midazolam infusion up anyway, and I think that, um, sometimes I feel would tend to sort of, um, we tend to be on the, um, we tend to give them a little bit, probably a little bit too much pain relief, just to make sure they're getting enough, rather than, um um, being on the other side, and I think that's quite, I think that's quite a good thing, because at the time it doesn't really matter to them whether they're too, you know, (Mm) drowsy, or it doesn't sort of influence their sort of, um, recovery at that point in time. (5,2,7-17)

Perspective

With a lack of visual evidence for pain, Patrick admits to sometimes overlooking this aspect of his role, I think its this sort of this this thing that you you've got none of your normal indicators that somebody's in pain that you just, I mean, it sort of seems sort of that it slips into the background a little bit (5,7,1-4) To Patrick, a phonecall from the patient's relatives can readjust a perspective that is overlooking patient comfort back to the person that is the patient, I know that when like when when we, when relatives ring to see, um, how the patient's doing, I think there's especially with the ones that are like really unconscious I think we'll always make a point of saying, "Well, they're comfortable and they're pain free," (Mm) and um, and I've guessed that they're pain free. (Laugh) ((*laugh*) Oh dear, (*laugh*) I hope that they're pain free.) (Mm) (*laugh*). But it sort of, um, if nothing else, it still makes you think, you know, "Is he really, he or she really pain free or not?" , you know, sort of. (*Yeah*) At least, you sort of, it comes back into your brain and sort of, and makes you sort of look at it again, and see whether they are or not. (5,20,13-25)

Patrick alludes to the part personal experience plays in assisting nurses to have an empathetic perspective when he tells of the importance of shaving to a male, I think that's probably very difficult to sort of um, sort of visualise for like say, female nurses, but like a shave in the morning, is just like, its beautiful, you know. You'd feel like, you feel alive again, and its nothing like getting out of the shower and having a good shave and um, so I'm like, one of the things I that I its like um, there'd be no way I wouldn't shave somebody in the morning, like, I mean, unless you know given its like (*Yeah*) you know you can't sort of expose them or something because its too cold or something its sort of one of those things is one of my sort of things is a guy's got to have a shave (5,11,30-12,3)

Assessment

Patrick is often able to imagine himself in the position of the patient and uses this to judge the patient's comfort level. When talking about suctioning via an endotracheal tube, Patrick muses, Well, your airway'd be so inflamed, and with, like coughing while you've got a, (*Yeah*) you know, you've got a brand new cold, I guess, (*Yeah*) and you can't breath in air. (5,5,27-30)

Appendix K

Attempting fiction - *enlivening the story*

In an effort to make the collective story engaging I attempted to create 'true' fiction based on the study's findings as referred to in sub-section 4.2.2.4 of the thesis.

You know, the other day I was given the guy who fell under the train to look after. I came on a morning shift and I thought he was OK, you know, just lying there, paralysed and sedated – looked fine. (The nurse looking after the guy with the head injury next door had even commented on the neat and tidy, comfortable looking patient I had. Poor Esrun, her patient was thrashing about the bed, kicking off his covers and squirming; not neat at all) I was busy looking through the charts when his sister came into visit and asked me how he was doing and whether he was in any pain. Now I really made sure he was comfortable. I assumed he was aware and that he would have pain from his injuries as well as our invasive interventions and even just lying still in the bed. You know, if I was lying there with no legs, fractured ribs, tube down my throat, tube in my side, drips and drains, I'd be sore. In fact I wouldn't want to know about it. I looked closely at him and saw that he wasn't sweating, his pupils were small, his BP and pulse were OK, he looked very similar to my brother. (My brother's a wimp; can't stand a finger prick for a BSL. I thought, "The IDC probably hurts this guy." but I knew he wasn't my brother.) I said to his sister, "He looks comfortable, though I'm sure he has pain from his injuries, it looks like its covered."

I wasn't sure how comfortable this guy actually felt, so I checked his infusions. The morphine and midazolam infusion was going at 5 mg/hr; not much for a big strapping bloke with no legs. I thought I'd take notice of any reaction when I suctioned him. There was nothing to see but it just didn't feel right. I didn't want him to feel discomfort, in fact I wanted him to not be aware of what he was living through or at least not remember it. I had a quiet word with Esrun who agreed that 10 mg/hr might be more appropriate. I increased it; ICU is a safe placed; he was monitored and ventilated. I documented the increase on the chart, but what reason would I write?

Esrun was getting hassled by the messiness of her patient. Even though she assumed her patient had a major headache which would be causing his irritable behaviour, the doctors wanted to assess his neurological state so she couldn't give him any narcotic or sedation. He was physically restrained but constantly in danger of dislodging some important attachment by his continual movement. Her constant attention to safety left her with little time to do the 'extras'.

The wardsman came around to help turn my patient. He was new. He hadn't been exposed to hospitals much – you could see it in his eyes when he was confronted with so much horror. He talked to my patient in great detail about what he was doing. The usual, "We're just going to turn you now." routine shift of position from left to right turned into a delicate operation of placing body parts where they looked the most comfortable, fluffing pillows, arranging tubing and other attachments – all because seeing through new eyes had given me a better picture. I saw that his saliva needed suctioning, lips needed moisturiser, his eyes needed to be cleaned, but I was pressed for time. My patient's lungs had been severely injured under the train and he was difficult to ventilate. I was very busy adjusting his ventilator, taking blood gases, suctioning blood from his tube, changing full ICC bottles, pumping in blood transfusions, keeping him alive.

Esrun came over to check some blood. She took a look at my comfortably positioned, still patient and confided, “Mine’s not comfortable, but I guess he will most likely get out of here.”

The next time I was assigned to the guy with no legs he had stop making urine because his kidney couldn’t cope with the massive blood transfusion he had received in the first few hours after his accident (mind you without the blood he would have died). So he was attached to a haemodialysis machine along with all the other usual hardware of ICU. As I looked through the notes and charts, trying to get my head around what had taken place between the last time I looked after him and now, alarms sounded, bags of fluid needed changing, this was going to be a busy shift. I managed to get all the observations down on paper, gave medications, took blood samples to measure his gas exchange and electrolyte balance as well as toxic level and blood clotting properties. Haemodialysis was going OK. It wasn’t until I suctioned him that I noticed his face screw up when he coughed. How much morphine was he on? Where was the infusion? I asked the ICU doctor,

“What happened to this guy’s morphine infusion?”

“You know the consultant – he doesn’t want him to have narcotics while he’s in renal failure.”

“It looks like it hurts when I suction him.”

“He probably doesn’t know much because of the toxins in his system.”

That was that then. What was I to do? The next time I came to suction him I was in a dilemma because I needed to get out as much sputum as I could (and I got the most when he coughed) but I didn’t want to hurt him. It was even worse when we turned him over – if he hadn’t been tubed I’m sure the sound of screaming would have changed the mind of the consultant. But there was nothing I could do except try to do things to him gently. Perhaps it would help to have some music on – did he like heavy metal or jazz? Or maybe I’d have time to clean his eyes and mouth more often, perhaps a back massage (in your dreams – there go the alarms again), well I could always think about the fun of going to the beach when I got off work.

Fiction – any similarities between real people and this story is unintentional

Do you know it was that sort of a day when you walk into the unit and the place is chaotic and you just want to walk straight out again. Esrun was tired. This was the fifth busy shift on a row. She was in charge, again. There were two new grads and two agency nurses and only one other nurse who could preceptor the new nurses and also be responsible for cardiac arrest calls. The other two nurses on this shift had been working in the unit for less than a year. Think. Get your mind here and not back at the apartment where there were piles of boxes yet unpacked from moving on the weekend. Which nurse do you allocate to which patient? Skill, proximity, strength, gender, schedule, history.

[Even though not directly to do with pain – shows what might be inside a nurse at a particular time re resources (the person who has the eyes)]

Esrun’s heart sank as the nurse in charge allocated her next to “that nurse”, the one whom she knew would have “things to say” to her during the shift. It had happened before. After saying hello to the patient and checking that he was ok, Esrun checked the oxygen, suction, resus equipment, alarms and infusions then went about assessing what was to happen during her shift. Next door neighbour nurse came over and said “Look at your bed area, it’s a mess.” Esrun knew that she would get to that but was going through her priorities. She said nothing, wishing that her neighbour would help rather than accuse. Esrun went about her work and managed to care for her patient,

restock and tidy the bed area. He was extubated but not very talkative, quiet, fairly still, not wanting to move much. In fact he didn't mess up the bed like most extubated patients did. When medication and fluids needed checking, Esrin went in search of other friendlier nurses and took the opportunity to dump her feelings about her neighbour's behaviour. It took a lot of time checking drugs! At last, the end of her shift. Esrin handed over. The nurse on the next shift appreciated how tidy the bed area was but noticed that no analgesia had been given during the shift even though the patient had an open neck wound.

[Shows effect of nurse bullying to distract assessment. (The focus of the eyes)]

Esrin thought of the ideal night duty; patient asleep, lights down, able to read a book in between obs and turns, uneventful, compliant patient in the morning for their wash. Ideal because the patient was getting the rest he needed to recover and ideal for Esrin because he felt lazy. Tonight it was not going to happen. His patient was a squirmer, constantly moving about in the bed, trying to pull at his trache tube, nasogastric tube and central line and arterial line. Esrin was annoyed. He tried to reason with the patient but was met with blank stares. He thought of chemical restraint and asked the doctors if he could give this patient propofol overnight to help him sleep but the doctors didn't want this patient sedated as he was trying to wean off ventilator support. So the patient was physically restrained with manacles but he increased his efforts for freedom including kicking out. Esrin felt exasperated and also at risk thinking he might be kicked, so he physically restrained the patient's legs. Esrin really didn't like this patient. The other nurses felt sorry for Esrin and came over to lend a hand at times when the patient was most active and for the dressings. So for 10 hours Esrin and the patient struggled. It wasn't until the next night duty that the penny dropped. During the intervening day, the patient had been given frequent doses of morphine and the change in his demeanour was obvious. He was calm, compliant and settled. Esrin considered what might have been.

[Shows internal resources of nurse and external constraints and shut eyes]

It was Esrin's second week into this rotation to ICU. She had been working in the orthopaedic ward before this. She was still getting used to all the alarms in ICU and juggling the vasoactive infusions. Today her patient was hypertensive and on sodium nitroprusside which the doctors wanted weaned as they had commenced oral antihypertensives and wanted the patient out of the unit and to the ward soon. As Esrin tried to get that mean blood pressure to the level the doctors had ordered, she managed to write down observations and give the medication but not much else. The clinical educator came and reminded Esrin that she needed to complete two clinical skills this shift and that she would come back to do them with her soon. X-rays happened and then the doctors round. New IV infusions were hung and visitors spoken with. Esrin felt overwhelmed with the amount of work that stood before her. Her patient's wife said to her, "Do you think he's in any pain?" Esrin automatically said "No, I don't think so." The patient had no wounds or any obvious pathology she thought would be painful. He had come to ICU post cardiac arrest outside the hospital. When the clinical educator came back to assess Esrin's two clinical skills, poor Esrin was just catching up on her work. The educator had a look at Esrin's patient and said something significant, "What about pain or discomfort as an option?" Esrin was willing to try anything so she gave some analgesia and was dumbfounded to find the blood pressure settled nicely. Instead of doing the mandatory two skills, the educator talked with Esrin and took her through the last few days the patient had experienced - chest compressions, myocardial damage, hypoxic brain injury, insertion and removal of an endotracheal tube and various venous access, urine drainage – the non obvious causes of discomfort.

[Shows lack of skill, shut eyes but they were opened through the educator]

What Esrin saw in the bed was a guy just like her flatmate Duhafj. She really like Duhafi, not in a boyfriend type of way but like a brother. Her patient had fallen 5 metres. Fractured thoracic spine, fractured ribs, fractured occipital bone, subarachnoid blood. Nobody knew yet whether he might be paraplegic as his vertebral fracture was unstable and he hadn't yet moved his legs. He was on a morphine infusion but was he getting enough? Esrin thought he looked comfortable because he was still with his eyes shut and the ventilator had no difficulty breathing for him. His blood pressure was on the low side though and Esrin thought about reducing the morphine, was he too bombed? It was time to suction him and while Esrin withdrew secretions from the endotracheal tube she watched his blood pressure rise significantly and then settle back down to the previous level. Esrin thought he probably only just had enough morphine to cover any pain experienced while just lying there but that he probably felt too much pain when she disturbed him with procedures. She decided to give a bolus next time before she touched him. Her heart went out to him and imagined what she would do if it was Duhafi in that bed. Maybe soothing touch or an extra wipe of his face or maybe just try to minimise disturbing him at all. Only remember to talk to him about where he was and what she was doing.

[Shows empathy and balancing – what is inside the person who has the eyes and hands – shows open eyes that are focussed]

Findings	Way forward
<p><i>Newby</i> - My heart beat a fraction faster as I clung to the side of the handover round. What would today hold? There were so many machines and seemingly all making noises at once and I was supposed to manage that cacophony. Which patient would I get? They all seemed so busy. What was that nurse like who had to "look after" me today? I shuddered.</p> <p>He had been shot in his chest. Drains, drips, ventilator. Priorities. Check the bedspace for safety. Check the alarms. Check the infusions. Oh yeah – say hello to the patient – introduce myself. Look at the paperwork. What do I do first?</p>	<p>After spending two days with Esrin I felt excited at the prospect of at last being let loose on the patients, with her backup of course. She always seemed to have the right words to say when I felt nervous and she was good at explaining the reasons behind what we did. We had worked out the best options of a couple of patients to ask for when the nurse in charge was allocating.</p> <p>My first patient in ICU – a man who had been shot in the chest 5 days ago. He looked like my dad. I went and touched his arm and said my name. "Its Wednesday morning and I'll be here with you until 4."</p>
<p><i>Patient</i> - I wasn't aware of much. Voices. Movement. Pain. Haziness jerking to momentary agony. I could here her rustling about me. Then her voice. She said her name. More nameless movements then the dreaded sounds of suction. I knew it would mean fire in my lungs and sharp stabbing in my side. I couldn't move. I couldn't stop her. I couldn't defend myself from going through this hourly torture.</p>	<p>I wasn't aware of much except the gentle touch and her voice that sounded reassuring like she cared and was there for me. Every now and then I would rouse to something making me cough or moving me but the discomfort didn't last long.</p> <p>They had told me I had been shot. I knew it was just a matter of time for healing to take place.</p>
<p><i>Oldie</i> - I was working beside this new nurse. As though I didn't have enough to do with my own patient. She was being continuously dialysed and had a sagging blood pressure. I went over the see if ms novice needed anything. The new nurse seemed to be ok in what she was doing but a bit hesitant.</p>	<p>I liked working with new nurses. It was so satisfying to see them move from nervous to confident, knowing that they made a valuable contribution to their patient's outcome.</p>

Mythical story

Gary came back from theatre. He was not responding because the anaesthetic was still on board. The first thing the nurses saw when the leads were plugged into the monitor was hypertension. The most inexperienced nurse immediately thought of antihypertensive drugs, the course student asked the medical staff if they could write up a morph and midaz infusion, meanwhile the in-charge nurse was connecting one that she had prepared before the patient arrived and, remembering what it was like when she had laid paralysed in an ICU bed (in his shoes), at the same time she was quietly telling Gary where he was, what had happened to him, what was happening now and what she was doing

Issues for discussion

person of patient versus technology
medical control of analgesia
impact of personal experience on care

Next day Gary was lying still in bed. New nurse was looking after him. Gary's mum asked her if Gary was in any pain. There was no analgesia. The nurse didn't know, what would she say? Gary looked comfortable, he wasn't moving or pulling faces or sweating, but the nurse knew that he went stiff when she turned him. The nurse asked the medical staff for some analgesia for turning, but was told that Gary's kidneys could not clear the drug. The medical staff didn't see Gary while he was being turned. .

Issues for discussion

priority of recovery versus comfort in ICU
seeing through other's eyes
feeling threatened when uncertain of own practice

When she did his dressing, the nurse remembered the awake patients she had done the same procedure for and what they had said they had felt during the dressing

Gary was dying. The medical staff had ordered morphine PRN but the nurse was afraid to give the drop that would actually cause Gary to stop breathing. The nurse at the next bed encouraged liberal administration of morphine, saying that dying was inevitably painful and should not be drawn out

One of the collective story editions was an imaginary shift where the nurses were a skill mix similar to my participants and the patients represented all types mentioned in my transcripts and events took place to cover the content of the present collective story but rather in a 'real' setting.

Another option is to have voices

for example,
the voice of the patient's body
or previous patients
or relatives
or doctors
pharmacy books
nursing care texts/policies
all imagined by the nurse
stand in conflict inside the nurse's head
nurse has to cope with them
which voices can be re-educated to not be in conflict

To explain the idea of eyes shut – we enter this dark room but we may chose not to enter because we don't think comfort and is as important as saving lives.

8am. The night duty team leader had finished telling us about each of the patients' medical conditions and what had happened on his shift. The team leader of the morning shift assigned each of her staff a patient to care for. I went over to the bed I was assigned to. The alarming monitor indicated the patient's blood pressure was low. The nurse going off night duty was busy hanging a blood transfusion so I muted the alarm. The dialysis machine was signalling 'effluent bag full', quickly, I went to swap the empty collection bag. When I returned the monitor showed a lower blood pressure – the night duty nurse was already preparing an inotrope infusion. Luckily the ventilator wasn't alarming. As I checked the infusion, she gave a brief handover of the events of the night. She should have been off duty by now, I didn't want to delay her by asking too many questions. I checked through the paperwork, adjusted the rate of the inotrope infusion, wrote down the obligatory hourly observations. At that point in time I was focused on keeping the patient alive, I had not considered comfort and pain. My whole time had been absorbed with ABC – airway, breathing, circulation.

As far as the metaphor goes – I had not entered the room yet – maybe it is an obstacle course or maybe there are other rooms one has to have in order before entering this one. Maybe we prefer to work in the light so we avoid entering the dark room.

To explain the idea of eyes closed as in asleep – we may be ignorant

I was looking after a patient who was waiting for a ward bed. Just getting a gown onto her was an ordeal. After threading the intravenous infusion line through the armhole, I threaded it over her arm but she jerked her arm away saying that the IV site hurt too much. To me it looked like a normal IV site – no redness or swelling – but it made me think that what I thought didn't hurt probably does.

We may not consider pain when we don't think that thing is painful

Appendix L

Philosophical options - *positioning the thinking*

In order to understand where I was initially located in terms of an empirical philosophical position compared to where I was locating this study within the interpretist framework, as referred to in sub-section 3.1.12 of the thesis, and also to provide answers to criticisms of narrative analysis as a way of doing research, as outlined in sub-section 3.3.3.6 of the thesis, I devised this chart using thoughts from (Bailey, 1996; Connelly & Clandinin, 1990; Crites, 1986; Guba & Lincoln, 1989; Kuhn, 1970; Linde, 1986; Lumby, 1995; Messick, 1989; Mishler, 1990; Polkinghorne, 1988; Robinson & Hawpe, 1986; Van Maanen, 1988).

Foundational Knowledge	the arrow shows the direction of criticisms: ← from → against	Pragmatic Knowledge
<i>logico-scientific cognitive mode</i>	complementary ways of thinking	<i>narrative cognitive mode</i>
aims at finding the truth (principles and laws)	→ Asks “where is truth?” - is story true or does it appear so because of discourse? ← Claims all knowledge is framed by metanarratives (‘science’, ‘religion’, ‘the enlightenment’) constitute or constitutive? (whether people ‘are’ because they live within a certain narrative or their ‘being’ impacts on the way their story is told)	aims at finding connections within context (shared exemplars)
testable via experiments (certainty in understanding)	← argues that experiments find out things in a developing manner rather than produce certainty in understanding → argues that language is opaque and distorting - not a mirror of reality	uses dialogue as a way of finding out and developing knowledge (dialogue may come to a temporary end point but not termination)
explanation → prediction	divergent forms of logic	significance ← outcome
objective	← argues that objectivity is really consensus	involves levels of interpretation (narrator, researcher, reader)
researcher must provide evidence of reliability/ validity and use of research	← new words life-like - authenticity meaning-making - apparency verisimilitude - adequacy plausibility - transferability trustworthiness - goodness invitational quality of manuscript	researcher gives details of method so that others can see whether what was done was trustworthy worth of research determined by its subsequent use by, and social impact on, community

Appendix M

Quantitative to qualitative - *shifting the thinking*

Early in my best fit methodological discovery quest, so as to understand the thinking behind my choices, I devised this table of comparisons between quantitative and qualitative approaches based on the work of (Guba & Lincoln, 1989; Schultz, 1987; Silverman, 1985; Speedy, 1990) as referred to in sub-section 3.1.5 of the thesis.

holistic inductive humanistic	PARADIGM	hypothetical deductive analytical
generating hypotheses developing theory illuminating understanding explaining describing	AIMS/INTENT	testing hypothesis predicting controlling phenomena discerning universal/context-free laws generalising
subjectivity inclusiveness equality engagement	CHARACTERISTICS	objectivity neutrality reduction control
naturalistic post-structural (constructivist) historical phenomenological critical grounded theory action ethnography feminist	INQUIRY	experimental
multiple realities (dependent on time and context)	PHILOSOPHY	one reality
interpretivist QUALITATIVE	APPROACH	Positivist empirical QUANTITATIVE
observe	METHOD	count

Appendix N

Exemplary stories - showcasing the nurses

Stories that the nurses told me which I think exemplify their practice as referred to in sub-section 4.2.2.5 of the thesis. There are only nine as one nurse did not relate an anecdote.

Leticia's story

1. Like the woman that I looked after last week who had malaena and haematemesis,
2. she had been on a sedation infusion of about two mls an hour,
3. very small lady,
4. and she had been unrousable on that,
5. or very lightly rousable,
6. she'd open her eyes, just, and that was it,
7. and seemed very comfortable,
8. and they stopped her infusion to wean her ventilation
9. and she was continually grimacing
10. and when I discussed that with the doctors they said,
11. "Well we don't want to put her back on the morphine infusion because she'll go back to sleep
12. and she has advance liver disease so can't give her panadol, you know",
13. we just couldn't give her anything
14. and I felt really uncomfortable with that,
15. and I was precepting a new nurse
16. and I said to her,
17. "I find it really difficult
18. because I want to, I want the patient to be comfortable
19. and I feel in a way embarrassed by asking because I knew she had advanced liver disease
20. but I hadn't really thought the whole process through before I asked the question (Mm)
21. I just knew that my patient seemed to be in pain,
22. and so I said, "Well what can I give her?"
23. and he said, "Well you tell me what you can give her.",
24. so then I had to think about all those things and,
25. um, he said, "I don't have an answer, I can't give her anything",
26. so, we couldn't
27. and we just had to watch her grimace when we turned her.
28. He felt that she was fairly encephalopic, you know,
29. a bit under anyway, (laugh)
30. so it wasn't going to be that much of a problem,
31. but (Mm) I sort of, I still felt uncomfortable
32. and I felt difficult about being with a new nurse
33. who I was trying to teach to be the patient's advocate and recognise when they were in pain (yeah)
34. and it yeah, I sort of said, "Well, sometimes you just have to ask the question
35. and be told no,
36. but at least you've asked the question."
37. So, whether or not they do that after, you don't know, so mm. (Pause 3 sec)

Asha's story

1. just the other day
2. we were lifting a lady back into bed,
3. a'an old lady with Guillain Barre,
4. fully aware,
5. and obviously a lady,
6. not that this should matter,
7. but she's (sigh) been a lady,
8. a very grand lady in her day,
9. she was 87,
10. you know who I'm talking about,
11. and she's obviously a a very modest lady as well,
12. like her daughter brought in her hair colour
13. because she'd just die if she knew that her hair looked like it did,
14. and trying to get someone to wash that lady's hair and put the colour in was impossible. *(Mm)*
15. You know, I'd go to do it
16. and they'd just say,
17. "Oh, just leave her, you know, we're gunna do physio now, we're gunna do something else now." and..
18. That was very important to her *(Mm)*, to have that colour in her hair.
19. Sounds silly but there was no need to *(Mm)* not do that,
20. but anyway,
21. lifting her back in bed,
22. and the poor thing had, you know, the wardsmen around the back of her,
23. and sometimes I look at things like this
24. and I know that there's no other way to do it,
25. but I you just feel so helpless
26. and and a young nurse at her feet doing a top tail lift back in bed
27. and she's all crunched over,
28. had this man's hands on her breasts,
29. which she must have just been horrified with *(Mm)*
30. and um, and they went to lift her back
31. and anyway he hurt her,
32. he hurt his back
33. and they just dropped her back in the chair *(Ohhh)*
34. and I just cringed when I saw it
35. but then I kicked myself because I should have said, you know,
36. "We need more people for this lift, we haven't got enough people." *(Mm)*
37. Um, but everybody forgot about her
38. because she couldn't speak,
39. she had a tracheostomy, you know,
40. I'l was standing there watching
41. and then I eventually went over and said,
42. "Are you all right, C?", you know,
43. "I'm sorry this has happened.",
44. explained what had happened
45. and um, but yeah, just because people can't talk. *(Mm)*
46. I guess its like people that speak another language,
47. you know when you're trying to speak English to 'em
48. you yell
49. 'cause you think they're deaf (laugh), you know,
50. just that they don't speak English. (laugh) *(laugh)* *(Yeah)*
51. And we've we've and y'you you speak to them like their idiots, (laugh) *(Yes)*
52. just 'cause they can't communicate in your own language *(Yeah)* mm,
53. and yet you know you forget th'that um, they're got hearts *(Mm)* and feelings under there,
54. but yeah, she was obviously uncomfortable,
55. she was scrunched in a chair
56. and dropped back into it,
57. poor thing, *(ha)* mm,
58. *(awful)*, yeah, it would be (2:9,17-10,20)

Robyne's story

1. it has happened to me twice (*Yeah*) in my life.
2. Both times on the unit.
3. Essentially, um, they said,
4. this guy was requiring so much adrenalin they'd pulled out
5. and he didn't have any family,
6. but that's a whole another issue. (*Yeah*)
7. You can't..
8. O.K. you don't have any family, forget it, um,
9. so they said, "Well we're ceasing treatment."
10. So I turned the ventilator off,
11. I, um, turned it down to 30%,
12. his saturations were, you know, about 40,
13. turned all the stuff off
14. and I gave him [an amount] of morphine in half an hour
15. and he was dead in about ten minutes. (*Mm*)
16. And I had no qualms about doing that at all.
17. I know that dose probably killed him,
18. but he would have lingered longer if I hadn't have done that. (*Yeah*)
19. But yeah, I mean, it puts you in a very moral position, doesn't it?
20. (*Yeah, yes and its an ethical sort of thing.*)
21. (*Yeah, yes and its an ethical sort of thing,*
22. *but its also a, if you just purely look at it from a comfort point of view..*)
23. I felt so,
24. I mean, in that instance I wasn't going on his grimacing, (*Mm*)
25. I was thinking how awful it would be,
26. how awful it would feel for you to be conscious and knowing that you were about to die, (*Mm*)
27. and I didn't want him to experience any pain whatsoever in that (*Mm*) time, (*Mm*)
28. and that's why I did that. (*And even..*)
29. And I, y'y and and because it was so hard to tell,
30. it was so hard to tell whether was experiencing
31. 'cause he wasn't doing anything (*Mm*) Um, you know,
32. it was like, "You gonna die,
33. I'm not gonna let this pain, you know, linger, (*Mm*) make it longer." (*Mm*) Yeah.
34. (*And also, like, if you were going by the things that would cause him pain,*
35. *I mean hypoxia*) Mm (*would be really uncomfortable, sort of*) Yeah
36. (*trying to breathe and..*)
37. And, you wor.. I mean,
38. situation on the ward too,
39. I remember a lady who, you know,
40. she was dying of cancer,
41. and she was basically scoring about three on the Glasgow Coma Scale,
42. and she had a KVO drip up,
43. and she was alive for about two days
44. just getting the regular doses of morphine that she would be,
45. and, I mean, that's a t'tragedy (*Mm*) I found, you know.
46. (*Mm mm, I g'guess that's another whole debate*)
47. But in, you know, in my, in those instances where they weren't grimacing, because their conscious.. level of consciousness was so..
48. (*But you knew when that they were going to die*) Yeah (*anyway*)
49. I you know, I would have loved to have intercepted and given them more,
50. but (*yeah*) I wasn't offer.. I wasn't in a position to do that. (*Mm*)
51. When I was in a position to do that, I did it. (3:7,4-8,7)

Bryce's story

1. I'll go to a situation where I think,
2. oh well I know
3. I was wrong in the situation,
4. um, not ICU related, cas related,
5. I gave a guy who'd come in,
6. presented with renal colic,
7. um, my mistake,
8. I had 2 mls of maxalon sitting there
9. plus a 2 ml syringe full of 100 mgs of pethidine.
10. I was to give the 2 ml 2mls of maxalon IV
11. plus, um, 50 IV and 50 IM of, um, the 100 mgs pethidine,
12. I thought I was giving the maxalon first
13. but I was actually giving him pethidine (*Mm*)
14. I gave him the 100 mgs of pethidine IV,
15. which is a big whack for a strapping guy of about my size,
16. um, and I absolutely nearly shit myself
17. 'cause I thought, "Christ, oh my god,
18. um, (*laugh*) what are we going to do here,
19. I mean this guy is gonna sort of stop breathing in ten, five or ten minutes."
20. um, but it actually turned out we had to turn around and give him some more IV pethidine (*Mm*)
21. because he was still kicking in pain (*Mm*) um,
22. that's what one situation,
23. OK you thought you'd gone too far
24. but actually you hadn't (*Mm*)
25. um, its not that hard, I mean,
26. I'd gone too far too quick, I know that,
27. I shouldn't have (*Mm*) done that,
28. I mean it would have been better to OK give him 50 IV,
29. not enough,
30. give him another 50 IV (*not enough*)
31. still not enough,
32. give him a little bit more,
33. in quick increments
34. and watch watch that
35. um, yeah there there's (*Mm*) that difference between giving someone too much all all of a sudden
36. and giving, not giving them too much,
37. you've got to try and find that fine line,
38. um, but I think that's a prime situation,
39. a an example of
40. um, yeah, ah,
41. not adequately assessing the pain
42. and ah, and sort of mm (4:20,26-21,15)

Patrick's story

1. I had a patient
2. and she was um, yeah, she was like at the stage where she just couldn't,
3. she just couldn't communicate whether she was in pain or not,
4. and and and, um, we had..
5. morph midazolam infusion was off because of the renal function and all that,
6. and we, not not out of comfort,
7. but because this was one of the last things we were going to try,
8. because of her lungs were really bad,
9. we turned her on her stomach (*Oh, really*)
10. and she looked really comfortable,
11. she just looked, she looked heaps more comfortable than, you know, (*laugh*)(*laugh*) when we put her on her left or right,
12. she would just sort of like had a pillow, um,
13. she like wasn't fully on her back,
14. she was just like sort of turned right over (*turned, yeah*)
15. and like sort of yeah rather having the pillow behind her back
16. had a pillow in front,
17. like she just had sort of the the tubes sort of coming (*Yeah*) out,
18. sort of a couple of pillows and the tube,
19. and, I mean, she looked really comfortable,
20. it was like one arm up sort of
21. and, um, (*laugh*)(*cough*) and sort of like,
22. "Oh," you know "Why don't we sort of do this more often sort of," (5:9,18-36)

Toni's Story

1. I think the person I looked after who was very well managed was um,
2. when I was working in intensive care in C with a burns patient. *(Ah ha)* *(cough)*
3. 40 percent burns
4. so we kept him,
5. we didn't transfer him.
6. We probably should have,
7. but we didn't.
8. It was mainly torso and face and things. *(Hm mm)*
9. and he was still ventilated at this point in time,
10. and when we used to do his burns dressings, we had an anaesthetic ventilator,
11. so we used to give him an anaesthetic to do his dressings, *(Oh, right)*
12. that was fantastic,
13. he would not flinch or move,
14. 'cause burns dressings, you know how traumatic *(Mm)* they are,
15. was like a two hour ordeal, just transferring him into the bath and those sorts of things, and do really, *(Yeah)*
16. full full thickness burns it was *(Yeah)* everywhere and, um,
17. we were really, you know, when he first came in we weren't very experienced with burns and things and, um,
18. it was just by chance that one of our registrars had worked in a burns unit somewhere else
19. and said "Well, you know, I think we should do this" and, ah..
20. The first dressing,
21. the first time we did his dressing,
22. it was just after he came in from cas
23. and he came upstairs
24. and he was just on, you know, a morphine infusion or something
25. and he was.. you could tell he was just grimacing in heaps of pain and those..
26. and no matter how many boluses were given it just wasn't effective.
27. And we all got a bit distressed
28. 'cause you could tell that he was in heaps of pain *(Mm)*
29. and it wasn't working.
30. So we we got him reviewed and that
31. and we decided to get this anaesthetic ventilator,
32. oh, you know, you could put the *(Yeah)* whatever is on the side *(the gas)* the gas
33. and you could titrate to whatever we thought he needed, *(ah ha)*
34. you know, you just check,
35. if if you go like this,
36. if he if he's if you flicker or twitch twitch or anything
37. and you could just increase it and that
38. and the anaesthetic reg used to stay there with us while we did it *(Oh right, yeah)*
39. and, um, that was great,
40. like you could do the dressings
41. and he'd be fine,
42. then you'd put him back into his bed or the chair and whatever you were doing
43. and it was really, it was really good.
44. He was just, you could tell he was obviously in no pain,
45. it was great. *(Mm)*
46. Yeah I thought that was very good. *(Yeah)*
47. Um, it was just lucky that they had this reg,
48. 'cause we, I mean, 'cause there's lots of ways you can deal with burns,
49. and, you know, they can be on lots of different things and stuff
50. but just it wasn't really working, *(Mm)*
51. and so this was really good, I thought,
52. having the anaesthetic. *(Yeah)*
53. Yeah, 'cause it was really short acting
54. and we could do it for the two hours it took to do all his dressings

55. and, you know, the OT's and physios would come and do all their treatments and things and he would be OK,
56. you know, it was *(Yeah, get it all together)*
57. Yeah, it was sort of all, it was quite good. *(Mm)*
58. That's probably the best one I think. Um, yeah, and *(5 sec pause)*
59. I suppose, one of the worst ones probably would be a little child we had who had, um,
60. a little baby,
61. oh he was about a year,
62. he had, um, osteogenesis imperfecta, *(Oh, yeah, yeah)*
63. you know, the brittle bones things
64. and ah he came in,
65. it was when I was in paediatrics,
66. he had fractured both his femurs
67. and he was in traction, you know,
68. and he just,
69. they didn't want,
70. in fact, he just wasn't really getting very much pain relief at all, *(Mm)*
71. 'cause they sort of thought, "Oh",
72. it was the paediatrician or the resident,
73. and I think he came in one night
74. and it was the morning until we got him sorted out,
75. and, um, they sort of thought, "Oh well, he obviously he sort of used to having lots of fractures." *(Oh)*
76. That was this resident's mentality on nights apparently,
77. and I was on that morning
78. and took over,
79. and and we said, "Aw, I don't think anybody's used to having fractures, you know."
80. And she said, "Oh, but he's got this disease."
81. And we said, "Well, no, you know."
82. So we got that sorted out,
83. but that was *(Mm)* probably all night
84. I think he'd been very uncomfortable,
85. the poor little fellow *(Yeah)*
86. and that wasn't very good.
87. It was just her perception
88. 'cause he would just lie there really quietly and not do anything. *(Mm)*
89. I think she thought he was OK
90. but I don't think he really was.
91. So that morning we got it all sorted out,
92. the poor little fellow, yeah. *(laugh)*
93. That's probably the worse one *(Yeah)*
94. to see these teeny weeny little legs up in traction. *(laugh) (Oh)*
95. He was a dear little thing. *(Yeah)*
96. He was just so tiny
97. and just looked funny, *(Yeah)*
98. and looked just *(just out of shape, yeah)* Mm,
99. and his mum had done it changing his nappy.
100. How would you feel,
101. it would be terrible. *(6:11,15-13,16)*

Rhea's story

1. They may not be experiencing pain,
2. but um, there's a certainly mental anguish
3. and *(Yeah)* things like that *(Yeah)*
4. and especially the likes of that,
5. do you remember that 16 year old boy?
6. I don't know if you would have looked after him.
7. He had the leukemia, um,
8. and his lungs were really shot
9. and they tried the nitric oxide on him for a long time *(Oh yeah)*
10. and eventually decided you know, that it wasn't going to cure anything
11. and and the mask was really irritating him and stuff
12. and so they they spoke to the family
13. and um, up to this he wasn't getting morphine and stuff
14. because he was getting the support of the CPAP and stuff um,
15. and they decided just to let him to let him go
16. and we explained to him
17. and he was in quite you know, quite prepared *(Mm)*
18. that we would give him something to keep him comfortable
19. because he was frightened. *(Mm)*
20. Um, so like the mental anguish of him, you know,
21. sort of terrified of, you know,
22. was he going to be gasping for breath,
23. we said, "No, we will give you the oxygen,
24. we'll just going to take that big thick mask off
25. so you can talk to your mum and dad and stuff."
(Mm)
26. Um, and that was good,
27. um, I thought it was well thought out
28. and there wasn't a question about it.
29. The doctor you know B came up
30. and said this is, you know, "we're going to give him some morphine and keep him.."
31. Um, we were giving him relatively small doses
32. but enough to keep him comfortable *(Mm)*
33. and as often as we felt it was necessary *(Mm)*
34. Um, you can imagine that it came to that
35. I mean, I know I don't know where that line is *(Mm)*
36. where you're giving that dose and the next thing they're asleep, *(Yeah, Yeah)*
37. but I don't think its wrong um,
38. think its wrong to sort of go along and give 200 milligrams of pethidine and bop them out
39. and then you give them 5 mg of IV morphine you're obviously going to suppress them *(Mm)* anything
40. but um, I think they've been pretty good, *(Mm)*
41. and I know its never been a question of having denied someone to give *(Yeah)* something um, analgesia in a case like that.
42. Um, in the majority of times it is for mental anguish. (8:20,11-21,11)

Taylor's story

1. I was up working on Neuro
2. and we had a lady that was..
3. they knew that she was she was dying, you know,
4. she was not NFR or whatever, *(Yeah)* she
5. I I actually, I thought she'd go on my shift
6. and and it was a big Greek family,
7. they were all in there with her
8. and howling, you know, *(Yeah)*
9. which is fine,
10. its their way of dealing with it,
11. but I remember, um,
12. I was in there
13. and and the relatives,
14. the daughters and that
15. were asking, you know, "What's she doing now?"
16. What's she doing now?
17. Is she.."
18. and I don't know if you've ever seen seen a patient
type of,
19. they jump *(Um)*
20. but they're still *(Yeah)*
21. they're still going *(Yeah)*
22. like their not dead
23. and I thought,
24. 'cause I'd never seen it
25. it was my first dealing with that experience,
26. so I didn't know if she was still..
27. I had to go up and feel *(Yeah)* the pulse to see if
she was still, ah, *(Yeah)* there
28. and I,
29. and the daughters going, "Oh, is she still alive?"
30. and I'm going, "Yeah, yeah."
31. But I found that really hard
32. 'cause they were,
33. the whole time
34. they were going, "What's happening now?"
35. and "When's she going to die?"
36. "When?" you know,
37. and she had a butterfly in her arm,
38. so I was just giving her,

39. she had PRN boluses any,
40. like any PRN like, *(Yeah)*
41. there wasn't any time limit, *(Yeah)*
42. and I I just, 'cause I hadn't worked with her,
43. I didn't know how PRN I could,
44. like how much *(Yeah, how frequently, yeah)*
45. how frequent I could give it like
46. and I remember just going up to the doctor
47. and, I knew, I mean, they knew she was going to
die soon *(Mm)*
48. and could see that she was in pain
49. and I just didn't know,
50. like if that little bit I give, I gave her
51. would pull her, or push her over the edge or
(Yeah)
52. I found it really hard *(Yeah)*
53. and then then the family being there
54. and, you know, "What are you doing now?"
55. and, you know, practically I was giving her her
last, you know, *(Yeah)* bolus.
56. I wasn't killing her
57. but I was making her comfortable. (9:12,36-
13,32)
58. And this person,
59. she was in renal failure,
60. she wasn't responding,
61. she was just laying there *(Yeah)* you know,
62. just gasping for every, *(Yeah)*
63. you know how they do. *(Yeah)*
64. Its very distressing to watch
65. and the family were there
66. and, ah, yeah,
67. so I I I actually had to go and query
68. with some of the senior staff or the doctors,
69. how how frequent PRN could I give it, like *(Mm,*
yeah) you know. (9:14,1-7)
70. I suppose, if you get, if you're covered legally
(Yeah) that's fine,
71. but I just didn't even know,
72. this was my first experience *(Yeah)*
73. I didn't know *(if you were covered legally, yeah)*

74. could I give it,
75. could I give it just ten minutely
76. or half hourly or *(Yeah)*
77. two hourly or *(Yeah)*
78. there was no order written there like.
79. *(It was just PRN) PRN (Whenever you thought)*
Yeah,
80. and I found that just a bit hard to, um, *(Yeah)* to
work out
81. and she ended up dying soon anyway,
82. but it was, it wasn't the nicest thing, *(Yeah)*
83. having the relatives there
84. and asking, "What's happening now?"
85. and you don't know,
86. like I'd never seen, you know,
87. I don't know *(Yeah)* you know,
88. they, I mean they were saying, "Is she in pain?"
89. Is she in pain?
90. Is she in pain?"
91. So I'd always say, "Well, you know, she looks
comfortable." *(Yeah)*
92. She did look comfortable
93. but how could you say? *(Yeah)* Like you know,
(Yeah)
94. she wasn't con',
95. she was lying there, gasping for breath, you know
(9:14,13-29)

Petra's story

1. we had one patient that was quite, um,
 2. he was actually quite with it,
 3. but with a um, a huge one-sided bleed,
 4. I think it was (Mm)um,
 5. causing a, I think, extensive paralysis
 6. and um damage to most centres
 7. but he was sort of looked aware (Mm)
 8. and although we sort of controlled his pain to a degree
 9. they were quite reluctant to sort of sedate him (Mm)um,
 10. although we were, you know, he was incapable of managing his own airway
 11. and we pulled the tube and (Mm)um,
 12. with the, you know, intension of allowing him to pass on naturally. (Yeah)
 13. Um, that, I mean in that sort of situation
 14. I just like discussed it with the doctors
 15. and if you didn't get a right answer from one
 16. you just went to someone higher up
 17. and (Mm)um, ended up getting him a midazolam order
 18. and in the meantime just sort of keeping his morphine right up.
- (10:5.23-6.2)

Appendix O

Pain and Sedation chart - recording the assessment

This is the chart¹ that was used in the unit at the time of interviewing. Analgesia was ordered by medical staff to be titrated to level 2 of pain as referred to in sub-section 1.3.3 of the thesis. The nurses used this chart to document pain assessment as stated in sub-section 2.1.4.7 of the thesis.

Place Patient Identification Label Here

SURNAME OF PATIENT _____ HOSPITAL NUMBER _____

TITLE _____ CHRISTIAN OR GIVEN NAMES _____ AGE (YRS) _____ SEX (✓) M F

ADDRESS OF PATIENT _____

POSTCODE _____ DATE OF BIRTH _____ CLASSIFICATION _____ MEDICAL OFFICER IN CHARGE _____

DATE: FROM _____ TO _____

PAIN LEVEL: Assess By Response To Most Painful Procedure In Previous Hour. Use Code.

C COUGHING S SUCTION M MOVEMENT
B BIG BREATHS P PHYSIOTHERAPY D DRESSINGS

IF ASLEEP LEAVE SQUARE BLANK

SEVERE	4													
MODERATE	3													
MILD	2													
NIL	1													
VITAL CAPACITY														
TIME		2200	2300	2400	0100	0200	0300	0400	0500	0600	0700	0800	0900	
MORPHINE BOLUS:MG														
MORPHINE INFUSION RATE: MGM/HR														

SEDATION LEVEL: MARK WITH X

MANIACAL														
AGITATED														
CONFUSED														
CALM & ORIENTATED														
NORMAL SLEEP														
DROWSY														
UNROUSABLE														
TIME		2200	2300	2400	0100	0200	0300	0400	0500	0600	0700	0800	0900	
DIAZEPAM BOLUS														
HALOPERIDOL BOLUS														

PAIN & SEDATION CHART

¹ In a phone conversation with the hospital executive office I was told that permission to reproduce this chart here was not required as it was not 'published', was no longer in use, and I had removed hospital identifiers.

Appendix P

Arranging the codes under Labov structure - *structuring the codes*

An example of one of the analytical tools I used, arranging the codes according to Labov's structure of a narrative as described in sub-section 4.2.2.1 of the thesis.

Abstract

Difficult thing to do - to assess and manage

These ICU nurses find it difficult to assess their patients' comfort and pain; in fact they feel that they are never going to be able to truly assess those patients who do not communicate with them, because the patients' circumstances are sometimes beyond the nurses' imagination.

Oh, um, it is, its an interesting topic because I think when people are.. especially most of our patients are ventilated and paralysed and sedated and things, **it's very difficult to ascertain whether they're actually in pain or not.** (6/1/23-26)

Um, it's always um, I think with this sort of patient that you're talking about, the ones that you just can't, that can't even grimace to sort of say that they're in pain and stuff like that, I think they're probably the **most difficult to assess whether they're.. are they comfortable or in (Mm) in pain?** (5/2/2-6)

Yeah (Mm) Um, I think it's just simply because **it's just so difficult to assess** I think (5/2/21,22)

Oh right. Um, it **it's always hard in that situation to assess** a patient (3/1/20,21)

Um, I think its something that we probably don't do well and something that, um, is **difficult to do** because you're using your, your ideas and the way you you think that person feels and putting them onto them and behaving accordingly (1/1/29-33)

She was quite capable of doing her own actions but, in in the opposite way she said, um, "You must hate looking after people that can talk back." and um, I said,"No" I said, "Quite the opposite." I said, ..."You like to look after people, and and **the best you can look after them is when you know what they want.**" Um, so when a person isn't capable of their own actions, you dep'depend very much on other people, including yourself, to try and interpret how how they're feeling, like their physical comfort and especially their pain issues. (4/2/21-32)

So um, I mean yeah, that's that's how I perceive it. If you can get some feedback it's good, but **it's very difficult** on the upper half, on our side **to try and ah, yeah, interpret that pain.** (4/3/1-4)

Oh, yes, ah it **it's a difficult area** because you can't get a person's verbal responses (Mm) often, um, and I **guess there's never gonna going to be a, er, a way whereby we can truly assess it**, I mean, if you you think of the definition of pain, and think it.. I mean, it's a subjective (Mm) feeling that that person expresses, um, which is interrelated with all their all their cultural and learnt values and and so forth so, we're never gonna be able to subjectively, (Mm) ah well, I mean, objectively actually evaluate someone's pain (4/7/13-22)

they would like do do you give them enough pain relief but um, that's a little more, that's a little easier to to assess up on the wards and they haven't got a tube jammed down their throat um. (4/23/1-4)

I didn't want him to experience any pain whatsoever in that (Mm) time, (Mm) and that's why I did that. (And even..) And I, y' and and because it was so hard to tell, **it was so hard to tell whether was experiencing 'cause he wasn't doing anything** (Mm) (3/7/22-26)

And I guess its d', **hard to determine** um, the longer term patients that um, get unwell, OK they're unwell to begin with, but they get (Worse).. their condition worsens, um, what kind of pain are they in now? (Mm) OK they're over their acute stage of their.. someone sort of slicing open their abdomen, but what, **what sort of type of pain are they in now?** (Mm) I mean that's **that's a difficult thing to try try and comprehend** I think. (Mm) I think **sometimes patients go beyond the scope of our imagination and experience** (4/12/3-12)

Difficulty is also encountered when these nurses are required to balance the fine line between providing comfort and ensuring recovery.

Well, you don't want to oversedate them, y'you know, you don't want them to be there in pain, so, you know, its a bit hard to know when exactly, you know, (what?) what's too much, what's too less (yeah, yeah) when you not getting any feedback. (yeah) (3/1/31-35)

Um, I'll think of it all when you go, (Yeah) what I should have said. (laugh)(laugh) I wanted to tell you about...um, no, only that I, yeah, I think its something that's difficult and and often the guidelines that we have to work in as nurses are unclear, because you you're not sure whether or not they want them completely sedated or you'll have a conflict of um guidelines and that sort of thing. So sometimes you, you know, neurosurgeons might say, "Keep them flat." and intensive care people say, "Keep their ICP below something." and if that means that they're a bit more awake then, you know, what do you do? (1/14/24-34)

but then you can also say, "Well, if he's in pain, you know, he he shouldn't have to be lying there in pain when you're turning him and those sorts of things, just to make sure that his neuro status is OK." (Yeah) But its sort of, you just don't, you know, you sort of.. (Yeah) Well yeah, it's hard I suppose, you.. what's the priority really? (Yeah) (6/5/7-13)

I guess you're biggest concern in intensive care when they're sort of really critically ill is um, their medical side of things, and I think to me that sort of needs to take precedent because um, I don't know, sort of they go off so quickly, that um, (Yeah) and so....I mean, "Do you want to have pain or do you want to be dead?" (5/10/7-18)

Orientation

Setting - noisy and busy

The aspect of the ICU environment which these nurses mention as impacting on their care of comfort and pain is the noisy but necessary machinery, which is connected to the patients. Without this attachment to technology, the patients would not be as safe.

and there's that noise, and there's like, you know, that total.. I'd be totally irritated by the environment (3/3/5-7)

I noticed this, I think with the younger nurses in ICU particularly because I think they're scared, they're new th'they're so worried about the ventilator, the monitor, the machines alarming, and you see them turning a patient, or when they're trying to sit them out or something like that, and you just think, "Oh, that catheter's pulling", you know, or "Watch her head" or, you know, "You've got the tube across here, its gonna be, no wonder they're gagging on the ventilators" so, um, yeah I'm always really aware of the patient's comfort more that the machines alarming, I mean, I always think ICU, an ICU patient is the safest patient you can have (2/1/27-2/1)

I think you're safer than a ward situation some of the time, because you've always got a doctor there, you've got skilled nursing staff at some stage, so I think we can afford to be a bit more careful of that rather than worry about machines alarming (2/2/5-9)

For these nurses, the environment of ICU is busy with demands on their time from other staff. Hurrying impacts on the patients' comfort and pain.

and I think we get harassed by other people too, (Mm) we all do and we do it to people I'm sure, everybody does it, you know when they're trying to turn someone and the patient's just coughing and gagging, sputum's pouring up the tube and, you know, you often say, "Let's stop, suction the patient and we'll go on then." and, you know, the the wardy or whatever says, "No, come on, come on, I've just got to do this." or x-ray says, "Look, (Mm) can we just take this x-ray?" (2/6/16-24)

Type of patient - not communicating, maybe in justifiable pain, maybe aware, may remember.

These patients are critically ill and not capable of purposive actions, however, what I meant sometimes needed clarification or was misinterpreted.

So what, when you mean like, incapable of pur'purposeful actions, (That's like..) do they mean that that they're they're capable of no actions at all or are they capable capable of actions that, um, are beyond their control, like ah.. (Well, yeah, they're they're capable of moving and such, but if you were doing a neurological assessment on them they wouldn't purposefully move your hand away. Like it would be like nonpurposeful) So you, it could be like a bit of thrashing and something like that (Yeah) Yeah, right. (4/1/28-37)

Y'you, I mean, there are those people that sort of wriggle around that aren't sort of, I mean yeah, (yeah) sort of really purposeful in any way (4/13/7-9)

I think with this sort of patient that you're talking about, the ones that you just can't, that can't even grimace to sort of say that they're in pain and stuff like that (5/2/2-5)

especially most of our patients are ventilated and paralysed and sedated and things (6/1/24,25)

The assumption that pain is universal to these patients may or may not exist.

I think pain is something that they all experience, and discomfort, um especially if they're an unconscious intubated patient (1/1/36-2/1)

If they're not grimacing, and maybe this is a wrong assumption, but maybe, you know, they're not they're not perceiving pain. (3/6/16-18)

A belief exists that pain is justified in these patients in ICU because saving life takes precedence.

I guess you're biggest concern in intensive care when they're sort of really critically ill is um, their medical side of things, and I think to me that sort of needs to take precedent....Yeah, so I think that, and I think ah its, I think it's very easy to meet it, not very easy, but I think its through that its easier I think for some to justify, um, that someone is in a little bit of pain, like (Mm) if um, as long as that's not for a prolonged period of time, is long that is is for like normally turning or or and as soon as we've turned him they can settle down I think. (Mm) That um, you sort of justify the fact that they're in a bit of pain, yeah. (5/10/7-26)

Some of these nurses assume these patients are aware and others assume that they are not aware.

just feeling dirty I th'..is another thing, you know, if um, if you felt you were sweaty or dirty or, you know, you felt you were smelly, I don't know how aware they are of that though, so I guess we've got to assume they are, (Mm) that's what I think. (2/3/6-10)

Having that awful taste out of your mouth, whether they could sort of realise that at the time or not, (Mm) you know, this sort of patient you wouldn't know, but it sort of becomes an issue later on. (5/3/19-23)

These patients can sometimes hear and remember.

She had a medical problem and I think it was a head because she was a, she seemed a little bit knocked off, but, I mean, she seemed okay but just a little bit slow and um she now lives at home and is fine or relatively fine, independent and can care and look after the kids and things like that but she came, I remember the day she came back and um she said "I can't remember anything except M, the name M", and like she actually felt a bond with M just because she remembered his name. (Laugh) Because out of everything that had happened that was all that she could remember. She actually said she couldn't remember anything (Yeah) and I thought that was real interesting, (1/8/35-9/9)

He was there, he was so sick, so long, and when um he was better and went to um, was going to the ward, a couple of times people um went down, JL, that's right, he said to her um, "Oh, you're the girl that did my nails, my toe nails.", and things that she thought he wouldn't 've remembered (1/9/12-17)

M was actually in a very bad car accident when she was younger and she was in an ICU, and um, she remembers a certain level of consciousness, and I think this is important to know too, and its, I I always think its a pity our patients don't come back and give us feedback on their time in ICU, um, but she said she was still having sleep/wake cycles, though obviously nobody noticed, sort of, you know, she must have still had her eyes closed or whatever. And she said she remembered one time waking up with this excruciating feeling in her hand, and it was enough to open her eyes and they were doing, I don't know, a stab for blood gases or putting in an IV or something, some sort of needle in her hand. She said nobody'd tried to wake her and tell her, um, nobody warned her it was coming, they just did it, and she said it was a terrible feeling, and then she remembers a commotion afterwards so she must have (Mm) put up her blood pressure or something. (2/8/5-22)

The insight of one nurse explains why patients may not give feedback to the nurses on their experiences in ICU.

I guess, it would be, it might be interesting to sort of, um, and I guess we never sort of all do that, where we sort of get patients who've we've had in for a long, or like for a reasonable amount of time and and talk.. get them.. (Mm) like talk to them about their experience in depth. I do know some of them come down and say, "Oh, thanks very much." But then.. (So, you haven't heard any patients come back and talk about anything in particular.) Um, (cough) oh, they've come back and they've talked about it and said, that you know, "Thanks very much and we got really good care here." Um, but I guess it would be interesting to to ask them specific questions about whether they were in severe pain at any stage and, um, did they feel pain, but were unable to com.. um, like communicate that they were in pain and and stuff like that. (Mm) (Cough) Whether they're at that time would be honest with you could be difficult to say, because it (Yeah) be pretty hard to walk into a place like that and say, "Oh, guys, (laugh) (laugh) you're doing it all wrong." (laugh) (laugh, yeah). (5/4/14-32)

Nurses - through education and experience they are equipped for their role as providers of comfort and alleviators of pain

These nurses believe their role is to manage pain adequately and to provide comfort.

there's a difference between giving someone relief over a lengthened period as to giving.. because you got to get rid of, you've got to get rid of pain there and then (Mm) its not a matter of saying "Let's wait and see." (Yeah) Um, because that doesn't do any good for the for the patient (Mm) um, so you've got to get rid of it then and not later (Mm) because the idea of pain management is to manage that pain adequately, its not, "Oh, let's wait and see." (laugh) that's not managing, that's, um, that's being um, what would you term its, its (like um) that's being mean (yes, laugh) yes, it is, its torturing someone (Yes) (4/17/26-36)

and if they're experiencing it then that's real for them, and you're, you know, you can't judge that you just have to, um, help relieve the pain the best way that you can. (3/5/13-16)

nursing's a skill on its own and I can't define it, I don't know how to define it; its about people, its not for us to diagnose or to to, um, treat, you know, describe prescribe drugs or treat disease processes, that's what doctors are for. (Mm) We're there for patients' comfort, and, um, a lot of things, you know, to coordinate all the multidisciplinary teams that we have, but, most of all we're there for patients' comforts and I think that's our skill,

looking at the patients, trying to get them comfortable, (Mm) and and safe, I mean safety patient safety has to come first as I said, but there's other things too. (Mm) The patient first and foremost. (Mm) (2/4/20-30)

OK, we've quelled the physical pain, but we want we want this person to feel comfortable as well (Mm) cause there's that thing, I I could, you could, if I was in physical pain, you could put me in a position where I was uncomfortable too. (Mm, yeah) So um, you got to try and get that person (laugh) its like a big fork isn't it, a two pronged fork, you've got to try and ah, (yeah) pick both things in one hit. (4/11/19-26)

Confidence in this role is found in experienced nurses, who can recognise subtle cues, are aware of patient individuality, know that ICU patients are safe, practice with a degree of autonomy and who in turn sometimes feel responsible for newer nurses.

Its something that, um, you can only manage well when you've had lots of experience at doing it, like I remember when I started, um, in the unit and people were on a morphine and midazolam infusion and they said, you know, keep them comfortable, I had no idea what to do (1/2/1-6)

I guess in a way its so experientially based, like you need to see, and a patient on one mg of morphine might be almost unconscious and somebody else on five mg might be climbing out of the bed (Mm) so you can't say, "Start you infusions at two mls and hour and increase them, you know, in hourly increments of one ml." and that sort of thing so yeah, to to be that rigid isn't really possible either (1/5/4-11)

I think, having been in the unit for four years that I can now, um, look at a patient and and see, fairly confidently, whether or not their analgesia and sedation is adequate (1/2/12-15)

I think with the younger nurses in ICU particularly because I think they're scared, they're new th' they're so worried about the ventilator, the monitor, the machines alarming, and you see them turning a patient, or when they're trying to sit them out or something like that, and you just think, "Oh, that catheter's pulling", you know, or "Watch her head" or, you know, "You've got the tube across here, its gonna be, no wonder they're gagging on the ventilators" so, um, yeah I'm always really aware of the patient's comfort more that the machines alarming, I mean, I I always think ICU, an ICU patient is the safest patient you can have, especially if they're tubed, they've got a tube down their throat, they're not going to stop breathing, you know, if they do, its very easy to look after, anything that happens to them you're going to pick up early, you know, (2/1/28-2/5)

but anyway, lifting her back in bed, and the poor thing had, you know, the wardsmen around the back of her, and sometimes I look at things like this and I know that there's no other way to do it, but I you just feel so helpless and and a young nurse at her feet doing a top tail lift back in bed and she's all crunched over, had this man's hands on her breasts, which she must have just been horrified with (Mm) and um, and they went to lift her back and anyway he hurt her, he hurt his back and they just dropped her back in the chair (Ohhh) and I just cringed when I saw it but then I kicked myself because I should have said, you know, "We need more people for this lift, we haven't got enough people." (2/9/30-10/4)

and some' you can pick up on it now, I mean before I started in ICU you couldn't pick up on. Oh you could pick up on it but I mean, um, it was a learnt thing when people weren't communicating with you you quickly learnt who was

a quite an anxious person and who was sort of tense, but then again there there are those that are very relaxed (4/6-12)

you know, R who we had for months, he was most comfortable on his left side. (Mm) Now I'd turn him for pressure care, if I had him on nights, but I'd leave him on his left side for a few hours 'cause if he was asleep, he's comfortable (2/3/31-35)

I think its all, you know, and I think it is all experience, definitely. (Mm) Some people are just, if you've been nursing, you know, fifteen years or something, you know you should, well theoretically, you should be able to sort of assess if your patient's in pain, a lot better than someone whose only been out a few years. (Yeah) But that just depends on your experience I suppose. (Yeah) and whether you're a bit more intuitive or (Yeah) yeah. (6/19/20-28)

One way of preparing these nurses for their role was through formal education.

my university education, and of course, we sort of like, so often through through uni, you know, they'd say, "Pain, what's if..", you know, "Some.. what are you thinking of?" It was always like, pain, y'you know, it was always the thing on the assignment if you neglected you lost ten marks, you know, its pain pain pain (Right) you've got to think about it and, you know, its always like pain is not up to you, its up to the person, its very subjective (3/5/1-8)

Oh yeah, I mean I guess the, I mean, ever since sort of I did my training, it was like pain an and comfort was always like sort of in the, it was like the big issue, I think, sort of coming in and and I think people sort of hadn't recognised that maybe they'd sort of been ignoring it a bit and and stuff and, so yeah, it was always like, the big thing was it, always like, "Make sure that your patient is pain free, and and that he's comfortable, and or she's comfortable." And once you'd done that then you know you sort of reach sort of a certain level. (5/1/30-2/1)

been to a few lectures with like pain management teams and things, which is always very interesting. (Mm) you know, and there's so many different ways you can control pain (6/8/4-6)

And having, like once you do the course you have a greater medical knowledge and knowing the consequences with people's haemodynamic status like if they're they're a bit hypotensive that you may not give them such a a great bolus of morph and midaz, or you might give them morphine and then give them the midazolam a bit later on or vice versa, um, 'cause having experienced people losing blood pressures and things like that because you give them both at once or whatever so yeah seeing things like that happen you think, "Oh my gosh, I've got to get this patient's blood pressure back up from 50, sort of thing (Mm) teaches you not to do that as well or to think twice about doing it and look at their condition as a whole picture and not just oh, they're in pain, but looking at it in the context of where they've come from, like whether they've just come back from theatre and they're hypertensive and so by giving them you're going to treat their blood pressure as well, or if they've just had a massive haemorrhage you know you want to keep them pain free as well, that sort of thing, mm, (Mm) (1/7/29-8/10)

Previous nursing positions shaped these nurses.

Well, I guess I was a general nurse for, what five years before I went into ICU, that was three years of my training, 'cause I trained in a hospital, um, so that has to help, that has to account for something. (2/5/3-6)

I worked in nursing homes on and off for three years when I was studying nursing, and I s'saw a lot of people in pain in those places that weren't particularly treated with, um, appropriate pain um, (*Mm*) you know, morphine or whatever, so that.. and I always sort of found that a bit sad, you know, its a bit distressing (*Mm*) and, I mean, its very visual too in nursing homes, I think, when you see someone in pain or they're dying and not given pain relief. (3/4/17-25)

And the first ward that I worked on was oncology and that was very big on pain relief (laugh) (*I imagine, yes*) and, I don't know, through like my rotation though uni, as well ah, you know, we went to various oncology wards and I, I just remember this particular incidence with, incident with this guy who had, um, lung cancer, and I was I was trying to sit him up and I like even th'the tightest tou', slightest touch on his back, you know, he was he was in such agony, you know, (*Mm*) and I found it like so hard to like believe that that could.. you know, that he was that sensitive, that he was in that much pain, (*Mm*) and that, you know, I sort of think about that, I'll always remember that. (*Yeah*) So so sort of distressed for him. (3/4/25-37)

I guess, depending on where you've worked and what kind of patients you've worked with, I think you can often pick people who've worked with, um, say oncology patients especially, where they're on large dose (*Mm*) analgesia as compared to just the medical ward or something like that, where where people aren't as tolerant (*Mm*) of, um, narcotics especially, um. And you're talking about giving someone, um, oh I mean, just huge doses of say morphine or or or whatever to to try and, ah, quell pain, and you can see that a person who who's had that experience is quite willing to give a large dose but but on the other hand be cautious about giving a large dose and giving it to the person when they've they know that they they are in that pain enough to tolerate such a large dose. (4/9/7-20)

I think um, they way I look at pain has just come through just experience in different situations, (*Hm mm*) people with pain. Like when I used to work in emergency, people normally came in in a very acute phase, (*Mm*) and um, then in contrast, you always get your chronic, long term back pain and those sorts of things, (*Mm*) and I think, just being able to, um, you know, recognise, what this person's obviously in, you know, acute pain and see what type of analgesia works compared to sort of chronic long term people and when we used to get oncology patients in you could sort of see the huge doses they used to get at home and then you know that obviously its not working when they still come in and (*Mm*)(...) in pain and uncomfortable so.. I think just sort of getting quite a broad look at different ways people manage pain (6/7/27-8/3)

These nurses have continued to learn through working in ICU; through trial and error, watching role models and receiving advice.

I remember when I started, um, in the unit and people were on a morphine and midazolam infusion and they said, you know, keep them comfortable, I had no idea what to do and people just sort of said, "Oh, leave it at two mls an hour or five mls an hour." and there was never any education as to the reason why it was at at that point it was only because you ran an infusion at two mls an hour and you saw that they were still awake and

uncomfortable and distressed when you moved them that you realised that you should turn it up to to five mls an hour. That sort of thing (1/2/3-12)

Um, I believe I had a very good clinical teacher when I did my course and, um, he was a hospital trained nurse as well and he he'd been nursing for a long time, a good fifteen years or something and, um, he was very comfortable with ICU patients and he, um, communicated really well with them, he always took time to talk to them, he was, it was good to see somebody who nursed an ICU patient, a patient, not nursed the ICU equipment, (Mm) um, and I guess we all learn by example and that's very important and I remember if he came on and saw us, you know, if the first thing we didn't do was go up and talk to the patient when we came on we were in big trouble (2/5/6-17)

I guess watching other girls, like a..whe..when you're in the learning phase, when you first um (Mm) start in the unit when you see, um, when you work with people like when you come from a general ward situation its a big hoo haa about giving S4's and S8's and that sort of thing and so you, like for me, I was quite paranoid about giving it and you gave it very carefully and in small doses and you triple checked it and all that sort of thing (Mm) and then to come into an environment when it's used so often and so liberally was quite a um a change in attitude and that took me a while to be able to do that and I think it was by watching um other girl, like other nurses in the way they were quite happy to give a bolus of midazolam or a bolus of morphine and just give it and it not work and give another one and and you know, doctors would say just give them a bolus of this and a bolus of that and seeing that it was okay to give and recognising that they are fully ventilated anyway and this, they may stop breathing but its not going to compromise their their lives, so learning those sorts of things that its okay to give them adequate sedation and analgesia by what I've seen the more experienced people do I guess at the time and then trying it myself. (1/6/24-7/8)

I think y'you also tended to look at other, at how other people sort of do it as well. (Mm) and I think sort of that I've learned a lot of of things of like, um, just sort of watching other people talk to their patients and and watching other people position their patients and stuff and and and ah, yeah, I think sometimes I probably could have been a bit more pro-active myself, you know, sort of sort of just watch somebody and think, "Oh, that's a great idea." you know, that's worked (5/9/3-10)

And just asking people when you're not sure, "Do you think I should give this do you think I should give that?"(1/7/24-26)

I probably, like in an intensive care setting I think there's been times where I've given far too much, and, you know, more experienced people come sort of after me and sort of um um they sort of say, "The pupils are a bit small here. (laugh) (laugh) Maybe we should turn this down from ten maybe to five at this point," (5/8/10-16)

Personal experiences also impact on these nurses as they approach comfort and pain care for these patients.

I've had narcotics before, obviously not in an ICU, and have felt uncomfortable, but I've been just too drowsy to communicate it, (Mm) and in the morning when the nursing staff come 'round they say, "Oh she slept all night." and even though, you know, you just sort of open your eyes and try to say, (laugh) "Help, (laugh) my my teeth

hurt”, but you can’t (laugh) because you’re too doped out, (*yeah*) and, I mean, that must be more so with our patients (2/2/27-34)

I suppose my father, he has had chronic back pain for as long as I’ve known and you’re sort of.. I’m always aware of that he can’t stand for too long, he can’t sit for too long, he can’t be in a car for too long, he has to have his legs straight, you know, there’s all these things that he can’t do, he can’t bend, you know, (*Mm*) and although he hasn’t taken a hell of a lot of pain for, ah control things for his back, you know, lots of panadol and stuff like that, and you know, he’s had a fair few operations, its always sort of made me think, from a young age, about pain, and how much, how distressed he became with it, because as my next, you know, next of kin really, he was m’like the most honest I think anyone would be with another human being, about the level of pain they’re experiencing, and, you know, and he always, ah you know what men are like when they’re in pain but (laugh) and that’s another assumption! (Laugh) You know, um, (*Laugh*) (*Sigh*) I suppose, yeah, I always find myself thinking when someone comes in and they say that they’ve got a bit of back pain, its like, “Oh my god.” (Laugh) “Lets get them something.” I suppose, yeah, that sort of.. (*Makes you more sympathetic towards them*) Yeah (*Because you’ve seen*) Help helped develop empathy towards people in pain. (3/3/33-4/17)

‘cause, um, my grandmother was in the S H Hospice for a few months last year, and we used to come up and visit her and things and the staff were just really really good. (*Mm*) But they were just really switched on, like you could, you know, like my grandma was, for six weeks she was just very, ah she was pretty much unresponsive like, you know, not doing very much, (*Mm*) and, but they were still, you could, they just had sort of their own, they were very, um, intuitive I think, (*Mm*) and they’d you know come and give her some morph and I would be there and I’d think, “Oh, you know, obviously, grandma’s, you know, I didn’t sort of think that she would be in pain. (*Oh right, yeah*) Well, I I just didn’t really know, you know, ‘cause she had, um, brain mets and things and I just didn’t really know, (*Yeah*) and, um, but, you know, that’s.. they’d come with the morph really frequently and those sorts of things, and they just said, “Oh, you know, we just, we just know.” And, you know, I think they.. (*Yeah*) ‘cause they see it on such a daily basis, (*Yeah*) you know, they were really really good. (*Yeah*) You know they had no hesitation whatsoever (6/18/31-19/13)

The end result of this shaping are nurses who are varied in their opinions on pain assessment and management.

(*Yeah, but it’s funny that that, like you say, that one person’s gut instinct is 3 or 4 mls out to another persons.*) Yeah, it’s like doing a multi-choice. Its, um, (*laugh*) I I think if you if you had the one patient and s’ got four people that were on that afternoon, I I re l’d lay a bet that you could a range of say.. if it was sitting there on say five and said, “Do you think he needs more or do you think he needs less?” and if you put a case down, the exact same case to each person, I think you could go from say about, a low of about three, one person saying, “No, I think you could start to wean it down a bit.”, (*Mm*) um, whereas a person may say, “No, keep it as it is, that’s fine.” and another person saying “No, I I think I’d increase it one or two just to see how it goes.” (4/14/4-16)

However, care of comfort and pain does not make up the total role of these ICU nurses.

But I think its, I think, um, we probably have a different, um, perception of thinking, than like like being nurses in intensive care areas compared to nurses who would work in a hospice, (*Mm*) or work you know on an oncology

ward, I think they would have a totally different view on pain relief, different perceptions and everything (Mm). I'm sure they would because, you know, they deal with that sort of thing on a daily basis. (*Its their focus*) Yeah, its their main sort of, you know, (Mm) sort of primary care type of thing (Mm) just to make people comfortable, and (Mm) I think that would be very interesting, 'cause I think they would have a totally different view of things (6/18/20-31)

because we mainly have people in the critical phase, its different pain management than people with sort of like a terminal (Mm) illness, um, when you tend to be a bit more liberal with the medications and things. (Mm) And, um, you tend not to have so many hesitations to increasing things and giving more and more, sort of more just so that they are comfortable. (Mm) 'Cause especially, I think, with oncology patients, there's no need to be in pain, (Yeah) you know, I'd be quite prepared to give large doses, because they shouldn't have to be in pain, you know. (Yeah) (6/3/29-4/2)

I guess you're biggest concern in intensive care when they're sort of really critically ill is um, their medical side of things, and I think to me that sort of needs to take precedent because um, I don't know, sort of they go off so quickly, that um, (Yeah) and so.. (*Is that because of the dichotomy between being dead or comfortable?*) Yeah (laugh) (*laugh*) that's right. "Do you want to be painfree, or do you want to be dead?" (laugh) (*laugh*) I mean, "Do you want to have pain or do you want to be dead?" (Yeah) Yeah, so I think that, and I think ah its, I think it's very easy to meet it, not very easy, but I think its through that its easier I think for some to justify, um, that someone is in a little bit of pain, like (Mm) if if um, as long as that's not for a prolonged period of time, is long that is is for like normally turning or or and as soon as we've turned him they can settle down I think. (Mm) That um, you sort of justify the fact that they're in a bit of pain, yeah. (5/10/7-26)

Doctors - status, attitude, time in contact with patient, and control of analgesia impacts on nurses fulfilling their role

Doctors enjoy a higher position in the hierarchy than nurses.

I think um, at times they don't really, um, take into account that you've been there all the time, like I think that they should actually try and discuss with you how the patient's been going, 'cause, (Mm) you know, they just come along and say, "Well we'd better stop the, you know, the sedation or stop the analgesia or decrease it or something. " You say, and then if you could, if they would just listen to you a bit more I think, (Mm) 'cause you've been there all day and you know how your patient is and (*and why*) and (*why you've got them to that state at that time*) to that point, time, yeah. (*Yeah, what's happened just before*) Yeah, exactly, so I think um, (Yeah) I think as nurses we're not often, sort of given enough credit for (Mm) being able to ascertain how uncomfortable your patient is or how they're too comfortable or whether they're getting too much pain relief or not enough. (6/6/33-7/10)

we could be a little bit more pro-active but then I think there's also, um, (4 sec pause) people are probably a little bit afraid of of what the reaction is from, um, (B, laugh) (Laugh), from the medical side (laugh) (*laugh*) (5/9/36-10/3)

I think we need to sort of continually try and sort of be a little bit more um, creative (Yeah) which is not, which is not encouraged from the medical side again, either. (5/17/28-30)

At times, these nurses have experienced an arrogant attitude from doctors where nurses' views are dismissed.

Making them more aware that they're the patient's advocate, this patient can't tell you they're in pain so you the one that needs to be able to look at them and recognise that they're grimacing and recognise that they're sort of moving towards a particular area of their body when you turn them or do something and what is it that they're responding to. Like the woman that I looked after last week who had malaena and haematemesis, she had been on a sedation infusion of about two mls an hour, very small lady, and she had been unrousable on that, or very lightly rousable, she'd open her eyes, just, and that was it, and seemed very comfortable, and they stopped her infusion to wean her ventilation and she was continually grimacing and when I discussed that with the doctors they said, "Well we don't want to put her back on the morphine infusion because she'll go back to sleep and she has advanced liver disease so can't give her panadol, you know", we just couldn't give her anything and I felt really uncomfortable with that, and I was precepting a new nurse and I said to her, "I find it really difficult because I want to, I want the patient to be comfortable and I feel in a way embarrassed by asking because I knew she had advanced liver disease but I hadn't really thought the whole process through before I asked the question (Mm) I just knew that my patient seemed to be in pain, and so I said, "Well what can I give her?" and he said, "**Well you tell me what you can give her.**", so then I had to think about all those things and, um, he said, "I don't have an answer, I can't give her anything", so, we couldn't and we just had to watch her grimace when we turned her. **He felt that she was fairly encephalopic, you know, a bit under anyway,** (laugh) **so it wasn't going to be that much of a problem, but (Mm) I sort of, I still felt uncomfortable** and I felt difficult about being with a new nurse who I was trying to teach to be the patient's advocate and recognise when they were in pain (yeah) and it yeah, I sort of said, "Well, sometimes you just have to ask the question and be told no, but at least you've asked the question." So, whether or not they do that after, you don't know, so mm. (1/5/14-6/13)

Oh, you generally find doctors pretty good. (Yeah) Particularly, like the registrars and the consultants, its only like the residents, I think, who are a bit (a bit unsure) they're a bit, you know, they don't, they want to do the right thing, they want to get the patients extubated too. (Mm) But g'generally they're even pretty good I reckon. (Yeah. I guess not recently, because I'm on nights, but I've had problems with patients who are in liver failure or renal failure) Oh. (and not on dialysis.) Yeah, yeah, and they like, yeah, **they've got that like grimacing,** (Mm) and they always say, "Oh its just the, um, uraema, uraemia, you know, (Mm, and I find..) I had, what was that guy in bed two? (I can't remember) That fell out of bed? (Oh yeah him, yeah) Yeah. (Yeah) Oh, that was horrible. (But I actually, um, I, um..) Oh, its supposed to be quite painful, isn't it, (Yeah) just the uraemic (Yeah) state..... I remember people have said that to me to, as well, "**Oh, its just the uraemic state, don't worry about it.**" (Mm) Its like, Oh.. (So do they not get any, any narcotic at all, or do..) Oh they do, I, I, yeah, I remember like them having it, (a bit) but its not taken as seriously I don't think, its sort of like, he was more sort of given it because, you know, you know that huge big wound he had and (Mm) the dressings and stuff like that. (Mm, just for that?) Mm (3/12/24-13/34)

Ah, I remember one night having a screaming argument with the registrar in another ICU I worked in, um, because he just wanted to give a tiny bit of morphine to a paralysed patient and saying, "You have to give them something sedative as well, you know, all the narcotic will do is just make them drowsy. You can't paralyse someone.." (Mm) and we paralysed this patient just on a bit of morphine and we just had this screaming

tachycardia, went really hypertensive and I just said, “We we’ve got to give them something.” and we were just pouring in the morphine, this was horrible, and we just.. he was a huge big islander boy, and he we he wasn’t ventilating (*yeah*) and, even though he was paralysed, he was just obviously a’awake under the paralysis and he was just.. it was really horrible to see him, we were trying to get the morphine in and what was happening was, um, we had the morphine on like a biflow and the morphine must have been running up into our maintenance line. So he wasn’t even getting any morphine. Oh, it was just horrible, and we ended up, I ended up just pulling, getting a syringe, ‘cause I knew he mustn’t have been getting even the morphine, (*Mm*) pulling the morphine out of the bag with the syringe and injecting it into another port, so I knew he was getting it, and he settled down eventually. But it was just horrible, you know (*Mm*) and, um, medical staff had gone and they didn’t, **they just didn’t seem to think it was a problem when we told them about it afterwards**, and that’s terrible. (2/8/28-9/16)

Because I think [medical director] is very much , he’s very much um, ABCD, you now, you know (*Yeah*) and if and so if if *G* is not in the options then you know, you just don’t use *G*(*Laugh*) (*laugh*) its not, you know. (*laugh*) which has, I mean, he’s he’s got his point, I mean there’s some very good reasons for doing that (*Yeah*) but I think there comes a point when we say “Well, maybe we should look at *G* or not.” (*In this case, for this person, (laugh)*) Yeah, and we’re not, sort of, I think, well, how do you describe that? Um, what did he say at the ball, um, he doesn’t, we don’t need university educated we just sort of um, I think he said something like, “We don’t need nurses with brains,” or something. (*laugh*) not the likes of *G* and I think it was that night or the next night he was still fuming about that. (*Laugh*) saying that they don’t need nurses with brains or something. (*Yeah, (laugh) I wonder, (ha) oh, its that’s another topic, I just wonder whether he says all of that in jest to) Mm(to get people cranky.) cough (Laugh) Ah yeah, he enjoys that too. (Yeah)(cough) (Yeah) He might have done that just to have a few females coming up to him and giving them a bit of a hard time. (Laugh) Hmhm. (5/18/29-9/16)*

Nurses are able to understand the doctors’ point of view.

Because they wanted to see if he was alert and orientated (*Ah ha*) yeah, ‘cause they were worried.. (*to assess his head*) yeah. (*Yeah, mm*) But **you can see their reasoning behind** it but then you can also say, “Well, if he’s in pain, you know, he he shouldn’t have to be lying there in pain when you’re turning him and those sorts of things, just to make sure that his neuro status is OK.” (6/5/5-11)

I mean, he’s he’s got his point, I mean there’s some very good reasons for doing that (5/18/33,34)

Yeah, I I think sometimes (*you just don’t know*) that doctors oh we all do it a little bit, (*yeah*) ah, y’you start to look from a different (*yeah yeah*) perspective, you don’t, um, look at the person, you start to look for the.. (*the systems getting better type of thing*) Yeah (*Mm*) yeah the um, when I say the medical, I mean the physiological (*Mm*) perspective rather than the, ah.. physiological sort of includes the physical pain but you start to look at, “OK if you’re liver’s shot,” you think well “OK what are we going to do about that?” (*Mm*) Um, OK you don’t want to start throwing drugs there (*Mm*) that the (*yeah*) liver’s going to try and break down (*yeah*) ah and excrete it. (4/19/25-35)

Contact with patients varies with these nurses in attendance during all procedures for a whole shift while doctors' intermittent visits are prepared and brief.

I think they normally come along just when you've given them a bolus or something, 'cause you've turned them and they think that obviously (*Its like that..*) they've been like that all day. ((*laugh*)*Yeah*)(*laugh*) Just, they come just when they're, you know, (*laugh*) you've given them that little bit too much of morph and they're asleep, then they say, "Well that's it, no more." (*laugh*) You know, and you just think, "Oh, (*laugh*) if they were there for 24 hours, they they'd know that this person is uncomfortable and (*Yeah*) is fully with it." but, you know, yeah its hard. (6/5/20-29)

One nurse thought it was worth mentioning when a doctor was present during painful burns dressing.

we decided to get this anaesthetic ventilator, oh, you know, you could put the (*Yeah*) whatever is on the side (*the gas*) the gas and you could titrate to whatever we thought he needed, (*ah ha*) you know, you just check, if if you go like this, if he if he's if you flicker or twitch twitch or anything and you could just increase it and that **and the anaesthetic reg used to stay there with us while we did it** (*Oh right, yeah*) and, um, that was great, like you could do the dressings and he'd be fine (6/12/3-11)

Doctors control the ordering of analgesia.

and there's times when you, when you feel a pa.. you know, there's times, I'm just trying to think. It was in C, so it wasn't here, so it was a while ago, and we had someone who'd had something and I remember, I don't remember the exact circumstances but I remember us nurses standing around the bed and arguing with the medical staff saying, "They must be in pain.", you know. And they were saying, "No, look at them." And we must.. obviously we didn't have pain relief up, but I remember they'd just had like a triple A or something like that and they them saying, "No, we don't want to give them anything." And us saying, you have to give them 24 hours at least or something like that. They used to do that a lot with our head injuries actually up there cause we didn't have neurosurg team and we used to get a lot of traumatic head injuries, you know, kids in car accidents (*Mm*) and things like that, all sorts of things, and they'd want to wake them up after twelve hours or something and they'd be cerebrally irritated, thrashing around the bed, and oftentimes I remember saying, "This kid's in pain, you know, we've got to give him something." "No, no, no, we can't give him anything." (*Mm, 'cause they're neuro*) And yeah, and um, you know, y'l felt that they were in pain because even though they were cerebrally irritated, well I guess, a part of it that I felt they were in pain was because they had broken legs or something as well. But that was it, somebody that had terrible fractures or something like that. (*Mm*) Anyway it doesn't mater what it was, but yeah, because they were a head injury, even though they've just had a stinking great rod put down their femur, you know, and their foot's been crushed and they've got facial fractures (*Mm*) um, because we used to get all horrible things like that, they weren't to be given any morphine, because they wanted to see what they did because they had a headache and they'd, as I said, they'd be thrashing around the bed, but oh boy, they must've been in pain, (*Mm*) as well. (2/14/5-15/5)

I think he would have been in a lot of pain, (*Yeah*) 'cause he had lots of fractures, but um, they were sort of.. first of all they took the midazolam out of his, um um, infusion, then they used to put it back in and then they tried to

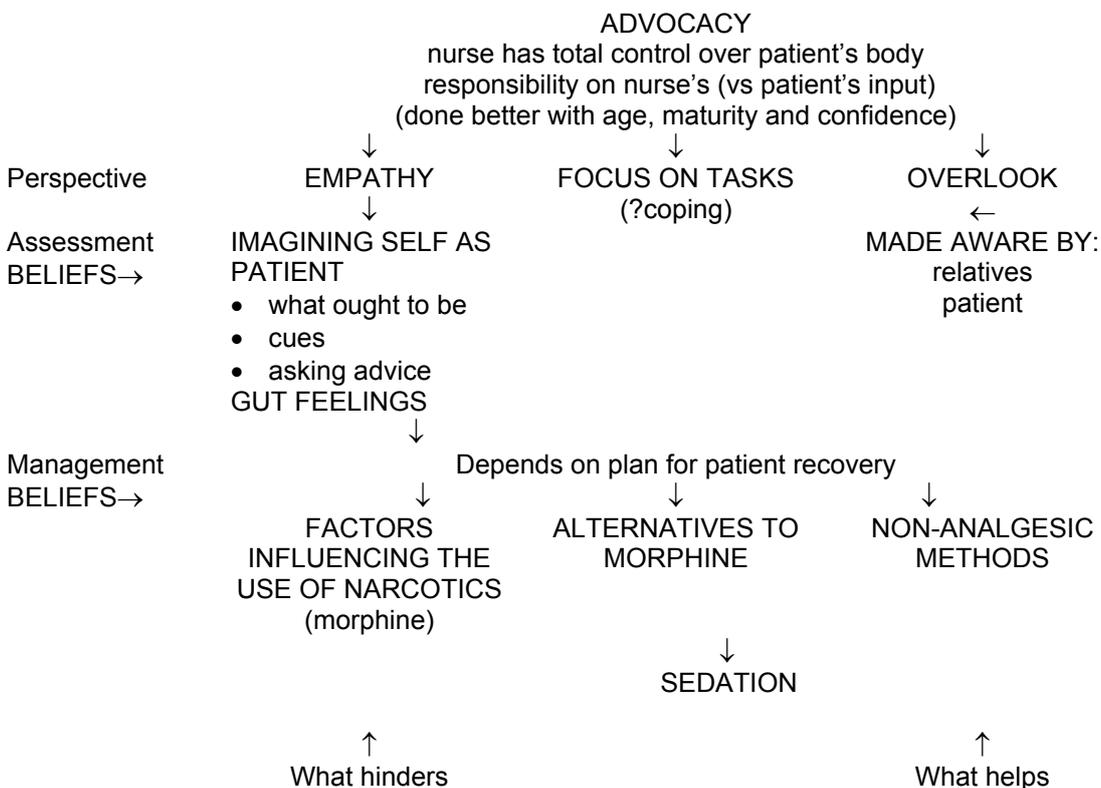
have his morphine on a really low rate and things, but, I mean, he would have obviously been in pain that gentleman, you know, (*Yeah*) and turning him and things, especially, they'd all sort of say, you know, "Only give him boluses if, you know, desperately required." and those sorts of things (6/4/28-36)

'Cause you can only do so much if you've got really strict orders as to how much (*Yeah*) you can give and.. Mm (6/7/16-18)

I think, um, we forget we're nurses, and nursing's a skill on its own and I can't define it, I don't know how to define it; it's about people, its not for us to diagnose or to to, um, treat, you know, describe **prescribe drugs or treat disease processes, that's what doctors are for.** (*Mm*) We're there for patients' comfort, and, um, a lot of things, you know, to coordinate all the multidisciplinary teams that we have, but, **most of all we're there for patients' comforts and I think that's our skill, looking at the patients, trying to get them comfortable.** (*Mm*) and and safe, I mean safety patient safety has to come first as I said, but there's other things too. (*Mm*) The patient first and foremost. (*Mm*) (2/4/19-30)

You know, of course when you talk about pharmacological treatment that's a medical thing. (*Mm*) Certainly we're the advocates and we can bring it to their attention, but as I was saying earlier, there's other things I think that we can do from a comfort point of view. (*Mm*) Mm. (2/15/11-16)

Complicating Action



Evaluation

(Attitude of narrator towards sequence of events)

Nurses' uncertainty

Uncertainty about pain assessment, about the goal of analgesia and about evaluation of care.

I think they're probably the most difficult to assess whether they're.. are they comfortable or in *(Mm)* in pain?
(5/2/5,6)

I guess the other thing is that if you know, I don't know, I guess, I guess you try not to, but I think that if your patient, is sort of..... (5/6/7-9)

Pain, you know, that's like the first thing you think of when they come back from theatre. *(Mm)* Or I do! (Laugh)
(Laugh) Um, is that wrong? (Laugh) *(Laugh)* (3/3/23-26)

I think at times you do tend to think, "Well, you know obviously they're in pain so I'll give them this." Whereas you don't really know, *(Yeah)* and its hard for you to know, yeah, its really, its sort of catch 22, if you don't give them something, they probably in pain, but if you do, whether they need it or not is another thing. Yeah.
(6/13/29-34)

'cause I don't know that we nurses, I mean, how do you ever know whether , ha! you do that *(Yeah)* well
(1/12/11,12)

Resolution

(Returns speaker to present)

Patient comfort is a measure of nursing

Living in a paradox (role conflict) constraints against achieving role

- patient advocate (BLOCKS: ancillary staff hassle, doctors discredit)
- make patient comfortable (human role at which nurses are skilled)

Experience gives autonomy and perhaps is escape from paradox

(Maybe the stuff that they say to me about me doing this research)

(O.K. thank you.) Not a problem, I enjoyed that and I think you sort of, I mean, stuff like that sort of makes you sort of think about.. *(Yeah, makes you think bout, brings it up to the front of your brain a bit)* Yeah, (laugh)
(laugh), out of auto pilot. (laugh) *(laugh)* (5/26/6-11)

Appendix Q

Coding notes - organising the codes

An example of one of the analytical tools I used, putting the codes together into one logical flow as described in sub-sections 4.2.1.7 and 4.2.2.1 of the thesis.

orientation to type of patient (clarification in interview 4)

Difficult thing to do

- to assess - nurses are never going to be able to truly assess
- as opposed to communicating patient who helps nurse to understand patient's needs
- hard to walk fine line - balancing

responsibility on nurse's (vs patient's input) - nurse has total control over patient's body
- ADVOCACY (done better with age, maturity and confidence)

neglect/aware/forget (easy for nurses to ignore, not obvious)
side effect of nausea can also be not obvious / confused with cues of pain

pain is universal to these patients is an assumption that may or may not exist

Experience (of the nurse)

- inexperienced nurses see machinery rather than patients, and are anxious
- experienced nurses more (but not totally) comfortable/confident with this aspect of nursing
- gives awareness of individual uniqueness and the limitations of formulae
- skill to recognise subtle cues
- gives autonomy (to sometimes break protocols)
- experienced nurses may feel responsible for actions of newer nurses
- experienced nurses realise patients are safe in ICU (monitored and ventilated)
- learnt experience (Education together with experience or experience educates)

Experience gained through

- seeing how patients in similar circumstances have reacted
- ICU experience important (be familiar with machines so you can see patient)
- ICU experience increases awareness of non-verbal cues
- trial and error (safe in ICU)
- drawing on other's knowledge
- role models
- personal experience
- oncology experience - see big pain and liberal analgesia
- uni education (nurses' role)
- geriatrics

What is pain?

- subjective/individual
- makes bp rise, patients go berserk, tense, rigid
- how is pain defined? theories inadequate, nurses' definition

Deserve pain?

What is comfortable?

- experience helps you know this
- comfort = not remembering
- comfort = somnolent
- comfort = flaccid muscles, relaxed

influencing factors on comfort

(list of things that make the patient comfortable or uncomfortable)

- cannula site

Consequences

	<u>comfort</u>	<u>pain</u>
patient - short term		delaying treatment not good for patient
- long term		
nurse - short term		
- long term (emotional)		

consequence of nursing actions

- analgesia may cause nausea so more discomfort

nurse wants patient to get better - will patient get better if body is in pain?

treating pain and comfort like a two pronged fork - pick both things in one hit

What is unconscious?

- patients can hear and remember
- sedation can cause “awake” drowsiness (but midazolam can cause amnesia)
- nurses assume that these patients are aware

Assessment

- categories of difficult patients (guillian barre, neuro, drug addicts, uraemic)
- visual (cues are subtle and complex) (the longer you look the more accurate your assessment)
- tactile - feel muscle tension
- cues used (grimace, tachycardia, hypertension, tense, agitated, rigid guarding, restless movement, sleep)
- sleep means comfortable or ‘narced’ out
- gut feelings about patient
- what ought to be - based on theoretical learning and based on experience of similar conditions (nociception - injury, tubes, uraemia) (acute pain - narcotics/relaxation or chronic pain - increased analgesic need/alternatives)
- imagining self as patient (empathy but some patients are beyond imagination) (see whole person - lifestyle)
- belief that pain needs to be measured to be treated effectively
- talking to people who know the patient especially spouse
- ask colleagues
- pt getting attention - going for tube = not comfortable (somehow subconsciously obtaining nurses’ attention)

Perspective

- nurse empathetic vs focus on tasks
- what's important for nurse vs for patient (long term vs short term view) (cannula site vs orthopaedic injury) (perspective on tube - belief that patient experiences are underestimated by nurses because nurses have not experienced them)
 - (suctioning as an example, is routine nursing procedure but horrible for patient)
 - (nurses may cope by seeing tasks rather than imagining self as patient)
 - (if nurses imagine themselves as patient, insignificant tasks become important)
 - (basic nursing care may be more important to the patient than what ICU nurses see causing discomfort)
- medical vs nurse perspective - physiology ("liver's shot" int 4)

Influencing factors on analgesia

- physiological parameters (link to education)
- goal of pain assessment
- nursing procedures (bolus)
- patient's mental state
- size of patient
- ventilation (decrease to wean or increase to breathe up)
- pharmacological paralysis
- contraindications (liver disease, neuro)
- level of consciousness
- relationship with patient (empathy or identification or nurse/pt relationship ie some patients make it hard for nurses to nurse) (belief that nurses should give equal care to patients)
- doctors' orders
- too much/ too less? (not such a fine line)
- everyone should get pain relief that is satisfactory to them
- what works (pain is individual and analgesia also has individual effect)
- base rate (based on nociception and previous patients in similar circumstances experience) + titrate
- general rates for different conditions fine tuned over time

Euthanasia

imminent death is a cue for giving pain relief
assumption that dying is painful

Alternatives to Morphine

oral panadeine forte
panadol

Non-analgesic methods

(take time and effort, demanding)

- pacing of tasks
- basic nursing care
- caring for patient/machinery interface
- talking to patient - nurses explaining and friends/relatives conversation
- washing/ positioning/ massage
- relaxation
- aromatherapy
- acupuncture

Restrictions/constraints (“locked-in”) limitations

- pain chart too narrow
- staff aren't using charts properly
- lack of communication from patient may lead to lack of identity as a person
- nurses position in hierarchy
- limitations on positioning of patient (physical condition, attachments)

DEAD ENDS:

living in a paradox (role conflict) constraints against achieving role

- patient advocate (BLOCKS: ancillary staff hassle, doctors discredit)
- make patient comfortable (human role at which nurses are skilled)

experience gives autonomy and perhaps is escape from paradox

nurses' role to manage pain adequately - as opposed to being mean/torturing

nurse has to cope with nursing in a situation where there is opposing forces - patient

looks like they're in pain and nurse asked to wean analgesia in view to extubate (Int4

20/17 - try to get the best out of both worlds)

varied opinions among nurses on pain assessment/management

same difficulty for evaluation of care as for assessment - lack of cues (“How do we know?”)

patient comfort is a measure of nursing

Problem solving

- hand it over to expert (pain team)
- preparation of patient (pre-op visit to unit)
- education
- objective assessment tool

Nurses' and doctors' differences about pain

- doctors dismiss what nurses see
- nurses spend more time with patient

Nurses aren't kind to each other

Emotions found in interviews

nurses' uncertainty

uncertainty about pain assessment about the goal of analgesia

feeling inadequate - not proficient at this aspect of nursing

happy

Abnormal/extremes/differences

male vs female experience/expression of pain

Appendix R

Nerilee's view - recording my position

I wrote this document before conducting the interviews as explained in sub-section 4.1.4.1 of the thesis. The content consists of answers regarding my own practice to the questions that I would pose to the participants as detailed in Appendix C. Essentially this is how I assessed, and what I did, to manage comfort/pain. This document, together with my spoken words during the interviews, is the substance of including myself as contributor as explained in sub-section 4.2.1.6 of the thesis.

When I look after patients that are unable to purposively communicate their state of comfort, I am not sure of their comfort. I base my care on an educated guess.

I think all of these types of patients would not be comfortable. I base my assumption on nociception, ie that their tissue has been injured eg by incision, pressure, anoxia etc. I also think that movement would increase pain by causing stimulation to the nerves around the site causing pain. So the times I would be most aware of pain in this type of patient would be on turning the patient or moving any body part (especially injured parts), doing dressings and suctioning (which makes the patient cough causing major body movement)

I assume they would be experiencing pain when they are not receiving analgesia, for example first back from theatre, or when analgesia is not ordered by the doctors.

Narcotic analgesia is my first choice for pain management in these patients because I believe it is quick and effective (based on education and seeing its effect in awake patients, no personal experience). I would try to get an infusion of morphine ordered (steady dose for patient and less work for me going to DD cupboard frequently). I would base the dose on patient size and injury and cues (grimacing, stiffening, sweating) and physiological parameters (BP, pulse). If I took over a patient, I would increase the infusion if the patient was exhibiting any of the above and the plan was to keep the patient comfortable, or I would decrease it if the patient didn't move at all and was completely floppy when turned, or temporarily for low BP (Treat the BP with something else because I do not believe pain should be a treatment for hypotension, I have seen this) or the plan was to wake the patient - then I have to walk the fine line of less comfort and more consciousness. I would give boluses of narcotic analgesia from the infusion before turning and before dressings if the patient exhibited signs of increased pain at these times and not at other times but I would prefer to have a steady rate all the time to prevent the possibility of me forgetting to give a bolus and feeling bad for the patient because I have caused pain unnecessarily or causing the patient to drop BP at the time of the bolus.

Theoretical learning has taught me that some analgesia is better than others for different types of nociception, for example, panadol is supposed to be more effective than morphine for bone pain, however, I have not seen concrete examples of this in practice. In our unit, the director doesn't like the nurses giving panadol because it is metabolised in the liver and can cause the patient's LFT's to rise. In our hospital it is a drug that can be nurse initiated, and often is given by new nurses for fever, but they soon learn not to give it. Analgesics other than morphine and panadol are not often used in our unit. The director, again, has the opinion that the less variety equals the fewer mistakes. Pethidine is given when morphine is contraindicated, eg, pancreatitis, but other pharmacological options are limited.

It seems to me that epidurals and PCA are off the topic as these methods are not used in the type of patient I am looking at.

To maximise comfort, other than using analgesia, I position the patient in a way that looks comfortable to me, taking into consideration their tissue injury, eg not lying on incisions or drains or pieces of ICU equipment. I would try to get a spanko mattress if the patient is thin or already has pressure areas. The routine in the unit is to turn the patient from side to side second hourly and only on their backs for washes and doctor's rounds. I generally follow this because leaving a patient might allow them more rest and less pain temporarily, but disrupted skin integrity or lung pathology would cause greater problems later. This type of patient is completely in my control, so I have to be aware of all their body parts and attachments when they are moved. Usually the wardsperson helps turn patients (or more if the patient is very large), and it is an issue that some wardspeople are rougher than others. I find it hard to tell the wardsperson I work with to be more gentle. He is not aware the this type of patient can experience anything, and he won't be told. After turns, I look at the patient to see if their body is in alignment. I usually turn the pillow over and pull it down to their shoulder and put the tubes, lines, drains etc into some sort of order and not tight. During my shift I clean the patient's eyes and mouth and wipe their face. How often depends on the patient. Often I suction the mouth after every tube suction, but clean it with mouthwash second to fourth hourly and do a proper scrub with toothbrush and paste when I wash the patient. Their eyes could need hourly to fourth hourly washing with saline and drops or ointment. Depending on how sweaty they are, I may have a wet cloth hanging by the bed to wipe their face and forehead whenever I walk by the bed. At the end of my shift, I wash the patient. I like to have the patient looking fresh and clean and comfortable for the next shift to take over. This is not always possible when the patient is a new admission or very sick, and I am happy that nursing is a 24 hour job so you can hand over a mess. I think turning to change the sheet (along side sitting up to take x-rays) is the most painful procedure for these patients and is when they would exhibit the most signs of pain and when I would be most likely to give them a bolus.

How I learnt

I gained theoretical knowledge through a pain management subject done for my BAppSc (nursing). Content of that subject covered physiology of pain and various pain management techniques as well as pharmacology. The patients it applied to were adult, awake and communicative patients. For the research subject, I did a literature search on pain in ICU and found very little. It was interesting to read some research on patients remembering their ICU experience and remembering pain, but that didn't help me to look after this type of patient. I've mentioned during the interviews the two patients who I heard relate their memories of their ICU experience and how that has affected my practice.

During my experience gaining time in ICU I watched other nurses and asked lots of questions. I think that non-analgesic methods of promoting comfort came from watching role models, whereas, the use of morphine was learnt more by asking questions. "What do you think?" type questions. I'm still not confident of my comfort/pain management skills, because there is not indication from the patient that I have done a good job in this area. I do my best and hope that is good enough for the patient.

I don't think that new nurses to ICU can be taught "how to" other than to make them aware of what to look out for and what options for comfort are available.

My concerns

Doctors control the most effective method of pain management - analgesia. In our unit, morphine is most often ordered as an infusion and titrate to level 2, meaning mild pain on nursing procedures. This give nurses a degree of autonomy during the normal course of events, however, some in situations the autonomy is removed. When the patient is to be "woken up" for neurological assessment or to wean ventilation, if the patient has some sort of contraindicating condition which prevents them receiving normal amounts of analgesia or then get none at all. During these situations, nurses are faced with a full 8 hours of managing a patient who would likely be in pain, whereas the doctors, who have left such instructions, may appear at the bedside once or not at all during that shift.

There could be more scope for non-analgesic comfort measures, especially in those patients who are receiving less analgesia. Less tunnel vision.

The importance of pain management in these patients because of the detrimental effects of pain - stress response - deterioration in condition etc. Don't use pain to keep up BP!

Appendix S

Analysis of Interview two - content and narrative

An example from Interview two of how I analysed using Labov's story form to analyse the nurses' anecdotes as described in sub-section 4.2.1.4 of the thesis. Non-narrative text was also revealed as 'train of thought' and referred to in sub-section 4.2.1.5 of the thesis.

a= abstract

o= orientation

ca= complicating action

e= evaluation

r= resolution

The nurse begins with comfort, giving a generalised story, not a specific incident. It is from her point of view as a more experienced nurse.

Story 1 (p1/21-30)

I hate

I hate comparing with other nurses

'cause I don't think we treat each other very well,

(yeah)

but there's sometimes,

and I noticed this,

I think with the younger nurses in ICU

particularly because I think they're scared,

they're new

th'they're so worried

about the ventilator,

the monitor,

the machines alarming,

and you see them turning a patient,

or when they're trying to sit them out

or something like that,

and you just think,

"Oh, that catheter's pulling",

you know,

or "Watch her head"

or,

you know,

"You've got the tube across here,

its gonna be,

no wonder they're gagging on the ventilators"

so, um, yeah

I'm always really aware of the patient's comfort

more that the machines alarming,

*maybe this is the
reason for the nurse
to notice rather than
act*

o

o

o new nurses see

o machinery rather

o than patient

o

o

o

ca

ca

ca

ca thinking rather

ca than saying

ca

ca

ca

ca

ca

ca

ca

e aware but does

**e this awareness impact
on patient care?**

Point of story: *The nurse is aware of patient comfort when she sees other nurses causing discomfort*

Non-narrative content*(p1/31-38) ICU is a safe place**(p1/38-49) how uncomfortable our routine positioning would be**(p1/49-p2/2) patients can still feel even though they can't communicate - to illustrate this point, the nurse tells a story from her own experience***Story 2** (p2/2-9)

the other thing is

we don't know how unconscious they are.

I've had narcotics before,

obviously not in an ICU,

and have felt uncomfortable,

but I've been just too drowsy to communicate it,

(Mm)

and in the morning

when the nursing staff come 'round

they say,

"Oh she slept all night."

and even though,

you know,

you just sort of open your eyes

and try to say,

(laugh)

"Help,

(laugh)

my my teeth hurt",

but you can't

(laugh)

because you're too doped out,

(yeah)

and,

I mean,

that must be more so with our patients,

*does she think that the
e really unconscious can't
a feel?***o****a***a maybe sedated patients
are aware***ca****ca****ca****ca****ca****ca****ca****ca****ca****ca****ca****ca/o****ca***In her own experience
ca this nurse was aware
but couldn't communicate***ca****ca****ca****e****Point of the story:** *The patients may be aware but too sedated to communicate***Non-narrative content***(p2/9-17) Put yourself in their place, especially considering thrush, pooling saliva, feeling dirty.**(p2/18,19) "I don't know how aware they are of that though, so I guess we've got to assume they are..."**(p2/19-23) ICU is a safe place**(p2/24-31) Put yourself in their position, especially considering their positioning**(p2/32-35) Physiological indicators***Story 3** (p2/36-p3/7)

that's another thing too,

y'you know sometimes,

like I know,

you know,

R who we had for months,

he was most comfortable on his left side.

(Mm)

Now I'd turn him for pressure care,

o**ca****ca protocol to turn**

if I had him on nights,
 but I'd leave him on his left side for a few hours
 'cause if he was asleep,
 he's comfortable
 and, um,
 he wasn't sedated
 so you certainly knew if he was comfortable or not.
 (Mm)
 So would he would tell you, like, or would he indicate
 Well no,
 no,
 the minute that I put him on his left side,
 he fell asleep on nights,
 but if he wasn't,
 like when he was uncomfortable,
 he fidgeted,
 he was awake,
 he was hypertensive,
 um,
 he was tachypnoeic,
 but if you put him on his left side,
 his resp rate fell,
 he obviously fell asleep to look at,
 his blood pressure settled down,
 just things..
 he didn't really communicate directly with you,
 as in look at you
 or tap
 or anything like that,
 but he was very fidgety,
 and I just think
 if you watched him,
 you could pick up
 (Mm)
 especially 'cause we had him for a long time,
 if he was uncomfortable,
 if he was just a bit off
 and was just fidgety from that,
 which he did at times,
 (Mm)
 or if he,
 um,
 yeah,
 if he was having a..
 some sort of hypertensive episode for no reason,
 you know.
 (Mm)
 So,
 and that's like B,
 the fellow with Guillain Barre,
 the minute you put him on his back,
 (Mm)
 with his head up a bit,
 he'd fall asleep.

ca 2nd hourly, breaks
 ca it on night duty
 ca
 ca assumption that
 a sleeping patient
 ca who is not sedated
 ca is comfortable

ca
 ca
 ca
 ca description is fast
 ca and different form
 ca of expression to
 ca the following
 description of comfort
 ca
 ca opposites
 ca
 ca
 ca

ca
 ca
 ca
 ca
 ca
 e use your eyes to
 e get clues of
 comfort
 e
 e
 e
 e
 e

e

o another incident
 o to add weight to
 ca point of story

ca
 ca

(Mm)

So there's things like that to consider, e
I think, e
a'above other things in ICU. e

Point of story: *Consider discomfort as a reason for restlessness, conversely, if you get the patient into their most comfortable position, they will sleep.*

Non-narrative content

(p3/7-14) *Definition of nursing - to provide comfort*

(p3/14-16) *Patient safety*

I asked the nurse to tell me how she learnt

(p3/25-27) *She learnt from general nursing*

she goes on to tell about her clinical tutor in ICU

Story 4 (p3/27-36)

Um,
I believe
I had a very good clinical teacher a
when I did my course o
and,
um,
he was a hospital trained nurse as well o
and he he'd been nursing for a long time, o
a good fifteen years or something o
and,
um,
he was very comfortable with ICU patients ca
and he,
um,
communicated really well with them, ca
he always took time to talk to them, ca
he was,
i't was good to see somebody who nursed an ICU patient, ca
a patient, ca
not nursed the ICU equipment, ca
(Mm)
um,
and I guess we all learn by example e
and that's very important e
and I remember ca
if he came on and saw us, ca
you know,
if the first thing we didn't do ca
was go up and talk to the patient ca
when we came on ca
we were in big trouble, ca

Point of story: *we learn by example*

The nurse then tells her story of being a new nurse in ICU.

Story 5 (p3/37-43)

I think again,	
I think,	
you know,	
like I said earlier with the younger nurses	a
and I must've been the same	a
when I first went into ICU,	o
I remember	
I was terrified,	ca
I'd stand	ca
and look at this ventilator	ca
and just think,	ca
"Oh my god,	ca
I'm never going to understand this",	ca
you know,	
and the mo..	
the first time I got someone with a Swan	ca
I was just an absolute mess,	ca
and I thought,	ca
"I'm never never going to be like those people	ca
who are so comfortable and easy with it all."	ca
So it is just experience	e
and time	e
and	
and being comfortable with the machinery.	e

Point of story: *new nurses in ICU see the technology as a challenge and may bypass seeing the patient.*

Appendix T

Each interview as one narrative - *analysing each narrative*

Based on the idea of 'life-story' I analysed each separate transcription of interview as detailed in sub-section 4.2.1.5 of the thesis. Here is a demonstration using Interview one. The line and stanza form for anecdotes is more fully explained in sub-section 4.2.1.4 of the thesis and shown in Appendix I.

Analysis Interview one (verbatim quotes)

Nursing lifestory of experience with pain/comfort in unit

The nurse's orientation to the topic

p1/26-28

is difficult to do because you're using your, your ideas and way the you you think that person feels and putting them onto them and behaving accordingly

p1/30-32

I think pain is something that they all experience, and discomfort, um especially if they're an unconscious intubated patient

p1/32-33

its something that, um, you can only manage well when you've had lots of experience at doing it,

The nurse refers back to the beginning, how she started and how she learned

p1/34-36

I remember when I started, um, in the unit and people were on a morphine and midazolam infusion and they said, you know, keep them comfortable, I had no idea what to do

p1/37

there was never any education

p1/38-41

it was only because you ran an infusion at two mls an hour and you saw that they were still awake and uncomfortable and distressed when you moved them that you realised that you should turn it up to to five mls an hour.

To her present role as CNS, quality assurance of pain charts

p1/44-48

we have those pain charts and I just, since I've just revised those, I realise how locked in we are to to a a thought pattern within that unit that we can't go beyond a level two categorisation of the patient, and that was something that I was trying to to change

p2/2-3

those categories are are fairly inadequate

Here the nurse provides a story to back up her point that categorising the patient is difficult

example 1 p2/3-13

1. for example,
2. the the patient that I looked after last night
3. was a head injury
4. who could move her left side
5. but wasn't conscious
6. and was quite purposeful with her left side
7. and would have extubated herself
8. yet she seemed distressed

9. and it was difficult to know whether she was awake
10. or un..un..um some sort of level of unconsciousness
11. and whether or not she was in pain
12. or she was in d,discomfort
13. it was fairly difficult,
14. and then when you had to write that on a chart, (Mm)
15. was she awake
16. or was she drowsy
17. or was she unrousable?
18. I found that really difficult to to categorise her,
19. so even though, um, you can have lots of experience,
20. it can be quite difficult still
21. to actually categorise what the patient's experiencing
22. and where they're at, um...

I asked the nurse to talk about the chart and she then explains more difficulties with its use

p2/23-43

cause that's what, um, they tend to, um, prescribe when they order a sedation infusion and an analgesic infusion, its always titrate to keep to level two, which is mild pain, so that they're not completely pain free, but um, they're comfortable rather than completely pain free, and that's a completely, um, subjective opinion of the nurse at the end of the bed, how she feels the patient responds to turning and treatments and dressings and suctioning and that sort of thing and even the difficulty with that is at the time you suction someone they might have abdominal pain because they've had surgery and yet in between times they don't move and their completely comfortable, so do you titrate their infusion for the time that they're being treated or do you, um, cope, you know, do you aim your management at in-between times (Mm) so...

What do you tend to do?

I think I tend give them a general level of comfort that they appear to be almost pain free and if I've, after my first initial hour or so with them and I can see that that's distressing for them, um, when they're being turned or, um, suctioned then I'll give them a bolus before I treat them if that's a, you know, their haemodynamic status allows that, then, um, that that's what I'd do to try and minimise the the pain for them during the procedures.

p2/46-48

trying to concentrate them at one point in the hour, instead of taking the whole hour to do all these things and continually going back to the patient and disturbing them.

p3/11-12

And just having had a look at a couple of the charts in the last week, I think they're really poorly filled out.

p3/21-25

Do you think that there are any answers?

(Pause 4 sec) Um

That somebody would be able to teach us, or

example 2 p3/33-p4/15

1. I guess, yeah,
2. there maybe aren't definite answers (Mm) for that,
3. but um,
4. maybe
5. maybe its an awareness thing for the staff (Mm)
6. Making them more aware that they're the patient's advocate,

7. this patient can't tell you they're in pain
8. so you the one that needs to be able to to look at them
9. and recognise that they're grimacing
10. and recognise that they're sort of moving towards a particular area of their body
11. when you turn them
12. or do something
13. and what is it that they're responding to.
14. Like the woman that I looked after last week
15. who had malaena and haematemesis,
16. she had been on a sedation infusion of about two mls an hour,
17. very small lady,
18. and she had been unrousable on that,
19. or very lightly rousable,
20. she'd open her eyes,
21. just,
22. and that was it,
23. and seemed very comfortable,
24. and they stopped her infusion
25. to wean her ventilation
26. and she was continually grimacing
27. and when I discussed that with the doctors they said,
28. "Well we don't want to put her back on the morphine infusion
29. because she'll go back to sleep
30. and she has advance liver disease
31. so can't give her panadol, you know",
32. we just couldn't give her anything
33. and I felt really uncomfortable with that,
34. and I was precepting a new nurse
35. and I said to her,
36. "I find it really difficult
37. because I want to,
38. I want the patient to be comfortable
39. and I I feel in a way embarrassed by asking
40. because I knew she had advanced liver disease
41. but I hadn't really thought the whole process through before I asked the question
(Mm)
42. I just knew that my patient seemed to be in pain,
43. and so I said,
44. "Well what can I give her?"
45. and he said,
46. "Well you tell me what you can give her.",
47. so then I had to think about all those things
48. and, um, he said,
49. "I don't have an answer,
50. I can't give her anything",
51. so",
52. we couldn't
53. and we just had to watch her grimace when we turned her.
54. He felt that she was fairly encephalopic,
55. you know, a bit under anyway, (laugh)
56. so it wasn't going to be that much of a problem,
57. but (Mm) I sort of,
58. I still felt uncomfortable
59. and I felt difficult about being with a new nurse
60. who I was trying to teach to be the patient's advocate

61. and recognise when they were in pain (*yeah*)
62. and it yeah, I sort of said,
63. “Well, sometimes you just have to ask the question
64. and be told no,
65. but at least you’ve asked the question.”
66. So, whether or not they do that after, you don’t know,
67. so mm. (Pause 3 sec)

Later in the interview, after talking about trying to fix it and feeling inadequate when you can’t, nurse referred back to this example p8/27-37

68. like that woman I looked after the other day,
69. when I don’t have an answer to her problem, (*Mm*)
70. I just have to,
71. how do I reconcile that to myself?
72. Well I’ve done all I can do,
73. now I’ve just got to turn her, (*Mm*)
74. and look the other way, you know,
75. or hope its not too painful
76. or try and reassure her
77. or something,
78. and reassurance, you know,
79. its like suctioning
80. doesn’t do anything, (*No*) really,
81. it doesn’t stop the pain,
82. doesn’t fix it,
83. so yeah,
84. if if you’re really concerned about,
85. if you have an empathy for your patient
86. then then that’s the sort of thing that you feel, I think.
87. And yet there’s other patients,
88. I’m speaking quite honestly,
89. that you don’t have any great affection for
90. and you just do the job
91. and you may not think so deeply
92. about um how much pain (*Mm*) they have

Back to methods of learning

p4/25

I guess watching other girls

example 3 *p4/44-p5/5*

1. like I
2. I just remember seeing um the girl who went off to Manly,
3. that um,
4. whose mum was in charge over there.
5. When I first came to the unit,
6. she was doing the course with um, S,
7. she had glasses, (...)
8. I can’t remember what her name is,
9. anyway she’s married now,
10. and um,
11. I just remember seeing this patient leaping around in the bed
12. and all of all of us were trying to hold him in,
13. and she just grabbed one syringe after the other
14. and just plied all this midazolam into this patient

- 15. and I just remember standing there
- 16. and being shocked at at the, you know how easily it was given
- 17. and I think that that sort of may be some...
- 18. you know seeing things like that is
- 19. just thought,
- 20. "Oh well, it is okay (*Mm*)
- 21. if they need it
- 22. well I'll just give it."

p5/5-9

And just asking people when you're not sure, "Do you think I should give this do you think I should give that?" And then realising further down the track that its okay to try it and if it doesn't work then you get something else, but if it does then you have the autonomy to do that and you can do that quite safely.

p5/9-11

once you do the course you have a greater medical knowledge and knowing the consequences with people's haemodynamic status...p5/18-20 and look at their condition as a whole picture and not just oh, they're in pain, but looking at it in the context of where they've come from

I asked the nurse if there were good or bad situations of comfort or pain that had influenced her

example 4 p7/38-p8/4

- 1. looking after the Guillain Barres was always a bad experience, um,
- 2. because they're so difficult to to assess
- 3. and to know,
- 4. like, particularly K.
- 5. I think that that was a really (*Mm*)
- 6. I mean,
- 7. I found that whole situation very difficult,
- 8. and um,
- 9. that I don't know
- 10. whether
- 11. why
- 12. but, um, you know,
- 13. I remember having conversations with the pain team
- 14. and, and um trying to work out what was the best management for her
- 15. 'cause she seemed so distressed
- 16. and so,
- 17. because she was so mentally capable (*Mm*) um, you know,
- 18. trying to preserve her her mental state
- 19. and yet decrease the pain in the rest of her body was so difficult (*Mm*)
- 20. to to give her something that was not going to make her dopey
- 21. and drowsy
- 22. and and unresponsive,
- 23. and I think that she expressed that as well. (*Mm*)
- 24. That that was something,
- 25. that um that was all she had
- 26. was her ability to to think (*Mm*)
- 27. because she couldn't move anything else,
- 28. when she was getting better
- 29. when she wasn't so sick and unconscious.
- 30. That that was a fairly difficult (*Mm*)
- 31. or bad experience, I think,

32. 'cause I don't know that we nurses, I mean,
 33. how do you ever know whether, ha! you do that (*Yeah*) well,

The nurse then spontaneously spoke of a recent learning situation

example 5 p8/37-p9/7

1. actually,
2. the other interesting thing with um,
3. actually thinking about
4. how much pain the type of procedure that they've had would cause them.
5. For instance,
6. the patient in bed 3
7. the other day
8. had a nephrectomy,
9. and we don't often have nephrectomies,
10. we have thoracotomies
11. and Ivor Lewis
12. and all those sorts of things
13. and S came in
14. and P had put his infusion up to 3 mls an hour,
15. this was a morphine,
16. um I don't think it had,
17. I can't remember if it had midazolam in it or not,
18. anyway,
19. he turned it up from 1 ml to 3 mls
20. and S came
21. and said
22. "he's only had a nephrectomy,
23. he hasn't had a thoracotomy,
24. he won't need as much pain (*Mm*) relief as someone who's had their chest opened.
25. And, I actually thought about that
26. and I thought,
27. "I wouldn't have thought about that if he hadn't've mentioned it." (*Mm*)
28. This was a big guy
29. and I would've thought,
30. "well, he's a bigger man he'll need more pain relief",
31. because we're used to painful procedures coming through the unit
32. where their abdomens are opened
33. and chests are opened,
34. and stuff, like that,
35. and so maybe education in those sorts of things (*Mm*) is where it would be more helpful
36. rather than how to use the drug,
37. a bit more about how to expect the patient to respond or something.
38. (*Yeah*) Yeah,
39. So I think that was something that I have never really heard anyone talk about
40. except in triple A's, you know,
41. vertical incisions as opposed to horizontal incisions.

More difficulties

p9/26-29

often the guidelines that we have to work in as nurses are unclear, because you you're not sure whether or not they want them completely sedated or you'll have a conflict of um guidelines and that sort of thing.

Suggestions on improvement

p9/36-41

maybe having a more effective tool that's less, um, subjective, but then if someone's unconscious there's no way that they can tell you, but I guess you go maybe using more physical signs of grimacing or or um you know localising to pain maybe something like that would be more effective than (*Mm*) standing at the end of the bed bed going, "Oh, they seem to have mild pain."

example 6 p9/46-p10/29

1. And I guess there's been a bit of controversy about the epidurals like,
2. have you been in the unit?
3. And we had two patients that had epidurals
4. post Ivor Lewis
5. a couple of weeks ago,
6. (*And they did really well*)
7. Yeah, and they did really well,
8. and this guy came back yesterday
9. that had an Ivor Lewis,
10. had an epidural in (*oh*)
11. and was given a large dose
12. and was commenced on a morph and midazolam infusion,
13. there was a huge mix up in the orders that were handed over to the nurse,
14. like the nursing staff didn't understand the orders that were given
15. so, um,
16. and it wasn't 'til at the end of the night shift that that became clear
17. when the registrar came in
18. and could clarify what was ordered (*Mm*)
19. and when all the correct information came out
20. we could then understand why we were not using the epidural
21. and this morphine and midazolam infusion was on
22. and like here were two, um, methods of pain relief being used in the same patient
(*Mm*)
23. and us not understanding what was happening
24. and why sort of thing
25. so when it was clarified it was good.
26. *Why didn't they want to use it (...)?*
27. Um, he had been given a bolus of, um,
28. I think it was 10 mg of morphine into the epidural (*ah ha*)
29. or it might have only been five,
30. either five or ten
31. and P was saying that that's a very large dose down an epidural
32. and that can keep someone, um, analgesed for up to 24 hours
33. and I didn't know that
34. and nobody knew that that's what he'd been given down his epidural
35. and there was talk about starting marcaïn and fentanyl infusions
36. and yet he had this morphine and midazolam infusion
37. and (*Mm*) so it was unclear as to at what point we could use the epidural
38. and um why he has this epidural in,
39. did he need the morph and midazolam anyway
40. if he'd had this bolus
41. shouldn't that have been adequate to (*Mm*) to cover the pain relief
42. and that sort of thing so, yeah,
43. and my impression
44. when I heard them talking this morning

45.was that the nurse hadn't understood,
46.or maybe she hadn't been told,
47.but he said that she had been told that this is what had happened,
48.and, um, you know,
49.if he seemed to have pain,
50.that the epidural was to recommence
51.and I don't know why the morph and midaz was continued.
52.It was all very unclear
53.and um difficult, yeah

p10/33-35

But I think, like there's lot of potential to do, to um, have better and more effective methods of pain relief that we just don't use because of doctors' choices and experience.p10/41-44 . Sometimes it feels like um we're denying the experience of other places in order to maintain our own, (Mm) which is a little bit narrowminded, but, um, that's the choice of management I guess.

p10/47-p11/1

I guess if someone comes back and says they can't remember it that's a good thing. (Yeah) Rather than, "I remember all this pain."

Appendix U

Collective story of one shift - *storying one shift*

Various versions of the collective story with alternate ideas referred to in sub-section 4.2.2.4 of the thesis.

First an incomplete alternate version

Our story lasts for a shift - we come to work, we stay our 8 or 10 hours then we go home. The next shift we work will be a different story. Yet past stories impact on today's story and in turn the story we live today will impact on future stories.

Location of the story; time, place and characters

Our story takes place at bedsides of critically ill intensive care patients who are unable to tell us their story - what they've been, their present experience and future intentions are not available. We are nurses at those bedsides interacting with the possibility of pain for these patients.

On this shift we arrive at work in various states of personal readiness for the activities to be undertaken. Having completed the post-grad ICU course at this unit and working here for several years, Letiticia feels at ease with expectations of her work and comfortable in her nursing knowledge - she also comes in good health with adequate energy. Asha's maturity and wide nursing experience over many locations and several different ICU's gives her confidence to value her nursing and provide encouragement and support to nurses newer to this setting - yet Asha comes tired. Although she hasn't completed extra study in ICU and isn't confident in her knowledge, Robyne's ability to easily empathise with patients gives her the basis for her care - she comes unconcerned, unperturbed, calm. Bryce also without extra formal study in ICU has experiential knowledge from general nursing locations, has an inquiring mind and is good at trying to get inside what patients might experience and considering treatment options outside the square - he comes keen. Even though Patrick is inexperienced in nursing he has a deep assurance of the worth of his contribution to the care of these patients - he comes energetic. Toni is experienced in various general nursing contexts as well as other ICU's and appreciates diversity in people - she is pleased to be at work. Beth is the expert ICU nurse, intuitive and knowledgeable, with many years spent in our unit - she is in-charge and feeling a bit timid. Rhea is our international import with some overseas general nursing experience and is presently doing the post-grad ICU course in our unit - she comes expecting learning opportunities. Taylor is new to nursing and ICU and is somewhat unsure of her knowledge and practice - she comes scared. Petra has just completed the post-grad ICU course and is secure in her nursing knowledge - she comes self-assured and confident. I am experienced and a researcher - I come with my eyes open to clues on pain care.

Beginning event; allocation

We begin the shift with a general handover then Beth allocates us each to a patient. We then go to the bedside and hear information from the nurse leaving the previous shift

Asha remembers having narcotic being too drowsy to communicate but being aware - also friend in ICU had certain level of consciousness. She also had a role model teacher who always demonstrated care of person rather than machinery.

Robyne's father had chronic back pain

Patrick waited in a waiting room as a visitor to ICU

Toni has experienced blood gas stab, her grandmother died in hospice and feels like the doctors should listen more and give her credit for what she can see.

Beth anticipates patients needs but doesn't want to 'rock the boat' with doctors.

Rhea has had personal experience of surgery, felt the pain and seen the variations in pain experience in others and she has worked on a surgical ward. She is good at picturing herself in the position of the patient. Rhea's bed is one of her precious places so it has to be comfortable. She has looked after someone who was rushed back to theatre and paralysed without sedation or analgesia and was able to report being awake under anaesthetic. Rhea suggests having more options to use for analgesia and having varied experience as a nurse helps. Rhea has concerns about euthanasia and relies on doctors to tell her how much is too much narcotic.

A more completed alternate version of collective story

Various nurses, doctors and other staff worked together for the benefit of critically ill patients in a major metropolitan teaching hospital's intensive care unit. On one particular shift, when my nursing colleagues and I were each allocated to take care of a patient, the unit was full of critically ill patients who were not able to respond purposively to us.

For a variety of reasons, some of us didn't notice any indication of discomfort and others didn't like the patient they were assigned to care for, a few of us focused on all the things we had to get done during the shift, rather than the patient's comfort, and decided to get our work done. However, when the relatives were visiting, or phoned, we were forced to see our patients from the perspective of their relatives who focus on comfort of their loved one.

Others of us thought that providing comfort was an important nursing role and judged a good nurse by how comfortable the patient looked. Because these patients were unable to tell or indicate to the nurses how they felt, some of us felt even more responsible for this type of patient's comfort.

Those of us who focused on our patients' comfort decided to look for indicators of comfort levels. To do this we looked, using our eyes and other's eyes, at the patient to see if they were comfortable. But we believed it depended on which eyes looked and for how long as to what was seen. The longer the look and the more the eyes have seen before, the closer to 'reality' was the view.

Some of us saw these patients as aware, even though they looked asleep, because some patients have remembered experiencing awareness while 'unconscious' and talked about it after recovering.

Most of us saw our patient experiencing pain when their blood pressure rose or they were tachycardic, restless, tense or sweaty. One of us saw large pupils as indicating pain or fright. All of us saw facial grimacing as an obvious behavioural gauge of pain, although this has been disputed by our medical colleagues in uraemic patients. Many of us looked at the physical tissue injury the patients had sustained and saw pain connected to this, and some even considered whether that pain would be acute or chronic.

Finding individuality blurred, some of us attempted to see uniqueness by looking through the relatives' eyes. However, often we could only rely on our own eyes and imagine ourselves as the patient. We visualised ourselves in the position in bed, with the tube down our neck, being suctioned, with physical injury, et cetera. Some of the newer nurses asked more experienced nurses to look as well and they collaborated the pictures they saw.

One saw older patients as feeling less pain, and another male's pain experience as worse than female's, because of their previous contact with these groups as awake patients.

But after all this looking, which took some time, we were unsure and found it difficult to know if these patients were comfortable or not. This difficulty was made worse when we had to fit the patient's comfort level into a category on the pain and sedation chart. There were also times when we felt discredited by the doctors about what we could see; we had spent more time with our patient during the shift and had seen the patient in different positions and during procedures, but often the doctor's believed what their own eyes saw during the round, rather than what the nurses' eyes had seen during the shift.

Even though the comfort levels of these patients was not completely clear, we believed all patients have a right to individualised quality nursing care and we wanted these patients to be comfortable, so they decided to do nursing activities that would provide comfort.

The first choice and most potent comfort measure we employed was narcotic analgesia. We controlled administration of narcotics to these patients, within medically ordered guidelines. A few of us were unsure what we were looking for as the goal of analgesia; some were afraid to give too much analgesia, while others thought that they should be liberal, knowing that ICU was a safe place. When adjusting narcotic doses, we once more relied on what they saw. We saw pain relief as a way of settling in new admissions, especially those who were hypertensive and tachycardic. Some of us used rules of thumb to work out how much analgesia to give, some viewed big patients as needing more analgesia, and others remembered awake patients with similar conditions, then again we looked for signs of comfort levels. When we believed we could see a more complete picture than our medical colleagues, we argued for analgesia for these patients.

One of us noted the possibility of causing discomfort through nausea when trying to relieve pain with narcotic analgesia. Although narcotics were most potent and most commonly used, there were many other things we did to promote comfort in these patients.

Some of us questioned turning and positioning of these patients because of the routine nature of this activity, in fact, for one of us, during routine care, the patient's trachy tube was nearly dislodged because the turning was treated as a routine rather than individualised; people were in a hurry. Routine's can cause nurses to minimise the impact on the patient and can restrict innovation. We gave basic hygiene care to these patients, thinking what it was like to be clean themselves. Some of us used touch, thinking of times when we saw massage or reflexology help. Most of us talked to these patients, to explain what was happening and especially as a warning or preparation for procedures, however, we used minimising, either because we were less sensitive to these patients' point of view or as a technique to reduce alarm in our patients.

We also gave these patients sedation, which causes amnesia, especially to those who were pharmacologically paralysed, in the hope that at least these patients wouldn't remember. Even while they were sedated, and especially if they weren't, we continued to assume these patients were aware and in some situations felt we needed to remind doctors of the possibility of awareness. One of us used sedation to mimic sleep patterns at night, while others knew that sedating these patients also made our job easier; sedated patients were easier to ventilate and they lay still.

Extra difficulty arose when we had to balance comfort and life saving treatments; we had to consider the whole picture. Some of these patients were too unstable to be turned, were hypothermic and could not be exposed to a wash, had pathophysiology causing the doctors to limit or withdraw analgesia and sedation to promote patient recovery, even though we saw these patients as experiencing pain. We knew that ICU was a place where comfort was not always the top priority. So often we justified some pain because we worked within a priority of recovery. Patients suffering neurological injury needed to be assessed, ventilated patients needed to be weaned and extubated, patients with liver or renal failure were not adequately clearing analgesic drugs. In these situations, we tried to be gentler, had to cope with seeing indicators that the patient was in pain, hoped the pain wasn't too bad, reassured the patient, and tried to be satisfied that we'd done all that we could.

For one particular patient during this shift, a decision was made to stop life saving treatments and allow them to die. The tension between comfort and recovery was eliminated, but for some of us was replaced by a tension between comfort and killing. We usually gave analgesia liberally, not wanting dying patients to experience any discomfort.

At a brainstorming session during the afternoon tutorial we had some suggestions to make on the topic of comfort care for non-purposive patients. We talked about education within the unit but ended up admitting that it is only through experience that eyes learn to see. We told experiences that had focused our eyes, both personal and stories from previous patients. One of us suggested patients could come back to share their experiences of ICU. We thought some sort of education on the topic would raise awareness.

Some of us related difficulties with doctors seeing differently to us and being in control of the analgesia, while others felt restricted by the unit's protocols.

One of us suggested a more holistic approach to comfort care based on the patient's lifestyle, while others volunteered that we could encourage a consideration of alternative narcotics and analgesics, but that choices should be based on research. Epidural analgesia was put forward as a way of avoiding the non-purposive state in a select group of ICU patients.

Some of us fantasised about an effective, objective assessment tool which would measure these patients' comfort levels. Two of us had concrete suggestions to make; measuring blood levels of endorphins, and statistically averaging pain for different procedures using awake patient's experiences as data.

One of us suggested a greater use of the expert pain team in the hospital, and also thought that pre-operative visits would help patients be prepared and thus more comfortable with ICU happenings.

However, at the end of the shift, we all went home not knowing for sure what comfort or pain these patients had experienced that day.

Appendix V

Interpretive notes - *noting my thoughts*

An example of one of the analytical tools I used, as described in sub-section 4.2.1.7 of the thesis.

Interview 1

Experienced nurses - do they make the patient more comfortable or are they more comfortable or both?

does filling out a form make the nurse more aware?

time lapse in assessment - what happens at each change of shift?

analgesia allows for free movement of the diaphragm.

sedation = easy to look after the patient

interaction between education and experience - education makes you use experience to better advantage or makes sense of experience

minimising J Lawlor

pre-op visit to unit - what's the point? good for nurse or patient?

stopping analgesia - at what point?

Interview 2

Does the experienced nurse notice rather than act because she thinks nurses don't treat each other very well?

Does being aware of the patient comfort rather than the machines alarming actually impact on care given?

"we don't know how unconscious they are" Are some patients that are unconscious unable to feel?

Whose time is important during procedures to patient?

If doctors order analgesia to be stopped to wake up and extubate, how does that relate to awake patients on the wards getting analgesia?

Is pain management more important than progress out of unit? (Analgesia/weaning ventilation)

Appendix W

Collective story in four episodes - *creating four episodes*

This is the first draft of the collective story using nurses' words within the Johnson and Mandler episodic folktale structure as detailed in sub-section 4.2.2.2 of the thesis. An outline for this first draft can be found in Appendix F.

<u>Setting</u>	Once upon a time, various nurses, doctors and other staff worked together for the benefit of critically ill patients in a major teaching hospital's intensive care unit.
<u>Episode 1</u> Beginning event: assigned to care of non-purposeful patient	<p>On one particular shift, my colleagues were each allocated to take care of a patient who was not capable of purposive actions. Bryce clarifies when you mean like, incapable of pur'purposeful actions, (<i>That's like..</i>) do they mean that that they're they're capable of no actions at all or are they capable capable of actions that, um, are beyond their control, like ah.. (<i>Well, yeah, they're they're capable of moving and such, but if you were doing a neurological assessment on them they wouldn't purposefully move your hand away. Like it would be like nonpurposeful</i>) So you, it could be like a bit of thrashing and something like that (<i>Yeah</i>) Yeah, right (4:1,28-37)</p> <p>Patrick's patient can't even grimace I think with this sort of patient that you're talking about, the ones that you just can't, that can't even grimace to sort of say that they're in pain and stuff like that, I think they're probably the most difficult to assess whether they're.. are they comfortable or in (<i>Mm</i>) in pain? (5:2,2-6) Toni especially most of our patients are ventilated and paralysed and sedated and things (6:1,24-25) Beth So are we talking about somebody that can't communicate at all, just even by sign (<i>Yes</i>) language (<i>Yeah</i>) or anything like that. (7:1,22-24) so we're most probably talking about a about a patient that's got head injuries, (<i>Mm</i>) very heavily sedated after surgery, (<i>Yeah</i>) yeah, um, accident victims, most probably head injuries once again or patients that have been sedated heavily for some other reason.(7:1,32-36) Taylor if they can't communicate if they've got, if they're tubed or, as you say, if they were sedated or something like that (9:2,17-19)</p> <p>Petra Paralysed patients probably are the ones that really um, fit into this category really well, (<i>Mm</i>) um, because they're still able to experience pain and wakefulness (<i>Mm hm</i>) and totally unable to um, react to it (<i>Mm</i>) purposefully anyway. (10:4,24-28)</p>
Simple reaction (1a) seeing tasks causes goal: complete tasks Attempt: do tasks	<p>For a variety of reasons, some nurses focused on all the things they had to get done during their shift, rather than the patient's comfort, and decided to get their work done. Patrick explains you've got none of your normal indicators that somebody's in pain that you just, I mean, it sort of seems sort of that it slips into the background a little bit (5:7,2-4) its sort of easy to slip into forgetting that there's somebody there (5:7,37-8,1) Robyne adds its easier to not, to neglect that area because they're not communicating, its easier to neglect that area because, you know, you're not getting any feedback about their pain level, you</p>

know, they're not doing anything. (3:1,22-25) **Taylor says** sometimes you've really got to think about it because sometimes you forget 'cause they're laying there and not speaking to you (9:9,33-35) but sometimes you don't even think, "Are they in pain." You just get on and do your job, (*Yeah*) you know, they look comfortable and they're not communicating, so you know, especially if they're on an infusion, you just don't bother, you just forget it like, (*Yeah*) that issue's been dealt with. (*Yeah*) I think a lot of nurses don't don't really think, "Oh but yeah, is my patient in pain?" like (*Yeah*) (9:20,26-33) **Toni agrees** I think at times often it might tend to get overlooked as well, because you often think, you know, perhaps your patient is OK (6:1,26-28) **Asha thinks** It's a big problem and I think the key thing is just to be aware of it as you possibly can 'cause people don't, they forget. (*Because they're they're honed in on the machines*) (*Yeah*) (*Yeah*). And everything, and getting that tube out or you know, weaning the ventilation (2:13,34-14,1) **but she admits to having her own needs** I'm sitting here feeling terribly guilty 'cause you know you get your patient turned and settled as quick as you can so you can sit down. (2:15,33-35) **Robyne acknowledges that the type of patient influences what she focuses on** generally, you know, you like all the patients, but if (sigh) I don't know, if it was like your mother in that bed, you'd be wanting to do absolutely everything for her. (*Mm*) The level of care you'd give her would be much better than Joe Blow off the street (3:10,3-7) **Leticia agrees** there's other patients, I'm speaking quite honestly, that you don't have any great affection for and you just do the job and you may not think so deeply about um how much pain (*Mm*) they have (1:13,14-17)

In fact, Robyne tells how nurses protect themselves from difficult patients for instance on night duty there was a guy once with HIV who ripped his cannulas out and was like spurting them at the ward staff and jumped out of bed and said, "I'm going to give this all to you." (*Mm*) you know and swearing, and its like well, you don't have much empathy for a pa'someone like that really. (*No*) And its like, "Well, OK, go." (laugh) (*Laugh*) "I don't care, (*Mm*) leave." (*Mm*) (*Yeah*) You know, its hard, and, I don't know, confused patients that say hurtful things, just have to like take it with a grain of salt. (3:10,8-17) **However, Bryce thinks patients deserve care from nurses** this person, ah, just just sort of bashed up someone and then the cop shot him, (*laugh*) ah, does he deserve that? I think you'd find people might be saying that, "Yes, he definitely deserves it." (*Mm*) Ah, but OK.. (*but if he came into ICU and you were looking after him*) Yeah he he still deserves the same same (*yeah*) degree of care (4:8,22-27)

<p>(but)Outcome: (complication not caused by attempt) see patient through relative's eyes</p>	<p>However, the relatives of Taylor's patient were visiting. She was forced to see her patient from the perspective of his relatives, asking questions that I really can't answer. <i>(Yeah)</i> Like, well, you know, sometimes you say, "Yes, they prob.. we we've got them on on a morphine infusion or whatever, <i>(Mm)</i> just that drips running", you know, and they say, "Are they getting pain relief?" I've had that question asked <i>(Yeah)</i> a few times and and sometimes they h'..they're not on infusions and and a lot of the h' head injuries and they they they'd say like, "How, are they in pain or.." and <i>(Yeah)</i> sometimes its really hard to assess 'cause the person is just lying there, you know, <i>(Yeah)</i> either, you know, you know, <i>(Yeah)</i> out of it or.. and and its hard and and its and I found those questions hard to answer because, as you say, you can't really <i>(Yeah, yeah you can't get inside that person)</i> tell yeah, yeah, and they don't look uncomfortable and their vital signs are OK and <i>(Mm)</i> but still you don't you don't always know if they're uncomfortable. <i>(Yeah)</i> So I found that a bit of a problem and I've had that question asked a few times and I've only in the short period I've worked in ITU <i>(Yeah)</i> think that the relatives are (...) I mean sure, they'd be really concerned and and <i>(Yeah)</i> anxious and ..<i>(9:3,16-37)</i> sometimes when they say, you know, "They've got the tube in their mouth, wouldn't that be hurting?" or <i>(Oh yeah)</i> or stuff like that, or, um, or just.. oh yeah and I I don't know if their.. I mean, its obviously a new environment <i>(Yeah)</i> to them to and and, um, and the person's operation, <i>(Yeah)</i> they'd be really concerned that that, you know, they were getting adequate pain relief or any pain relief, or.. <i>(Yeah)</i> But I just found it hard that one time, it was a person who couldn't communicate.. <i>(9:4,9-17)</i> it was a head injury, and he, a's you say, all his vitals were OK, he was just laying there. He looked comfortable <i>(Yeah)</i> and but the relatives kept asking me, "Are you sure they're not in pain?" And and they weren't on any infusions or anything and <i>(Yeah)</i> and I wasn't certain that they weren't in pain, you know, <i>(Yeah)</i> they weren't doing any of the obvious, um, signs that, vital signs or tensing up or <i>(Yeah)</i> or anything like that but I I don't know what I even what I said, I said, "Oh well, they look comfortable." Or something like that, <i>(Yeah)</i> because they did look comfortable but I <i>(Yeah)</i> for sure didn't know exactly if they were, you know, <i>(Yeah)</i> they couldn't communicate to me <i>(9:4,24-35)</i> Taylor gives reasons for the relatives questioning they could've had an experience in hospital <i>(Yeah)</i> and, um.. <i>(and they think that..)</i> Yeah, or just seeing the person laying there with tubes and <i>(Yeah)</i> drips and drains in, they.. <i>(Yeah, and imagining what it would be like)</i> Yeah, and they might think, "Well, that would hurt, or that the patient, you know, might feel uncomfortable or.." <i>(Yeah)</i> But, um, yeah I've had that a couple of times, that's why I've <i>(Mm)</i> I said that, but, yeah, you probably wouldn't see it as much. <i>(No, not at the moment, yeah, I'm sure that I've been asked that before.)</i> Yeah, oh they're just concerned <i>(Yeah)</i> worried relatives <i>(Yeah)</i> you know, <i>(Its fair enough)</i></p>
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	<p>concerned about the person (9:5,11-22) I remember this patient didn't have anything going (<i>Yeah</i>) and it was a hard question to ask us, (<i>Yeah</i>) like, or answer, because I, you know, he wasn't pain.. well I didn't know he was pain free for sure, (<i>Yeah</i>) he looked comfortable and and, um, you know, and still the questions are, "What's going to happen next?" and, you know, (<i>Yeah, yeah</i>) "Are they going to survive?" and stuff like that and its stuff that you just can't an'answer and.. (<i>Yeah, and they want to know</i>) Yeah, and and you just try and refer it to the, you know, (<i>Laugh</i>) to the doctor. But but I just find those questions quite hard to.. (<i>Yeah</i>) and not having and not being that experienced either, you know, (<i>Yeah</i>) you just palm it off onto someone else. (<i>Laugh</i>) (<i>Yeah</i> (<i>Laugh</i>)) It's a best way. (9:5,36-6,12) 'cause.. (<i>You don't know what to say</i>) and sometimes you think you're going to say the wrong thing or, (<i>Yeah</i>) you know. (9:6,19-21) sometimes your getting cases that, you know, a lot of the relatives.. not a lot, but some of them are involved in health professions (<i>Mm, yeah</i>) and they know what you're.. like sometimes you get RN's or, (<i>Yeah</i>) you know, people that.. we've had a few patients that the relative's have been doctors and, you know, they really watch you when you're doing stuff and they know, you know, they know what you're putting SNP up for and stuff like that. (<i>Yeah</i>) You know, you just feel like you're getting watched all the time, (<i>Laugh</i>) (<i>Laugh</i>) getting assessed by the relatives. (<i>Laugh</i>) (<i>Yes</i> (<i>Laugh</i>) <i>I'm sure they do, yeah</i>) Oh, its ah, yeah, but um, so I suppose there are a lot lot of different knowledge, you know, (<i>Yeah</i>) levels (<i>Yeah</i>) and stuff. (9:6,29-7,5)</p> <p>There was a phonecall enquiring about Patrick's patient which also caused a shift in Patrick's perspective when relatives ring to see, um, how the patient's doing, I think there's especially with the ones that are like really unconscious I think we'll always make a point of saying, "Well, they're comfortable and they're pain free," (<i>Mm</i>) and um, and I've guessed that they're pain free. (<i>Laugh</i>) (<i>laugh</i>) <i>Oh dear, (laugh) I hope that they're pain free.</i> (<i>Mm</i>) (<i>laugh</i>). But it sort of, um, if nothing else, it still makes you think, you know, "Is he really, he or she really pain free or not?", you know, sort of. (<i>Yeah</i>) At least, you sort of, it comes back into your brain and sort of, and makes you sort of look at it again, and see whether they are or not. (<i>Yeah</i>) (5:20,13-25)</p>
<p>Simple reaction (1b) important nursing role to provide comfort causes goal find out if the patient is comfortable</p>	<p>Patrick measures nursing by looking at patient comfort Make sure that your patient is pain free, and and that he's comfortable, and or she's comfortable." And once you'd done that then you know you sort of reach sort of a certain level. (5:1,35-2,1) I don't think it's a fear instilled in you in in during your training but its its I think it's a very big issue in your training and I think that its very hard to its very hard for nurses to measure how effective they are and one of the, um, very few things that we can sort of have a direct measure of what sort of job we're doing is whether someone is in pain or out of pain,</p>

	<p>painfree, and I think that's why (<i>Mm</i>) we sort of like tend to sort of, um, make sure of that, you know. (<i>So, if your patient looks comfortable and everything (Mm) then then you've done a good job.</i>) Yeah, that's right, a direct measure I think (5:23,23-24,3) because any other things like you've just got so little control over like with blood pressure and stuff, there's no measure of whether whether you're doing a good job or not or whether the wound's healing or not, because that's not.. (<i>Yeah</i>) I mean, you can do things but you can never actually say, "Well, (<i>that's because I did that</i>) Yeah (<i>laugh</i>) because I put you on the zinc (<i>laugh</i>) and that's why your wound healed. (<i>laugh</i>) Um. (<i>laugh, yeah</i>) so that's one of the very few things where you get a direct measure (<i>Yeah</i>) of how well you're performing (5:24,13-22) Asha sees her role as a skilled provider of comfort I think, um, we forget we're nurses, and nursing's a skill on its own and I can't define it, I don't know how to define it; its about people, its not for us to diagnose or to to, um, treat, you know, describe prescribe drugs or treat disease processes, that's what doctors are for. (<i>Mm</i>) We're there for patients' comfort, and, um, a lot of things, you know, to coordinate all the multidisciplinary teams that we have, but, most of all we're there for patients' comforts and I think that's our skill, looking at the patients, trying to get them comfortable, (<i>Mm</i>) and and safe, I mean safety patient safety has to come first as I said, but there's other things too. (<i>Mm</i>) The patient first and foremost. (2:4,19-30) Asha remembers a colleague who provided comfort well and who she considers to be a good nurse I remember, um, one of the girls in my critical care course, beautiful girl, really lovely, she used to be a nun until she fell in love (<i>laugh</i>) and um, she's one of those girls, you know, we all used to say if you were ever sick, the first person you'd have look after you would be M, she was just wonderful, little Irish girl, and um, she.. I remember the charge nurse, well one of the girls, the associate charge nurses in coronary care was really big on having everything clean and tidy around you're bed and she came up to M once and she said, "M you're environment is a mess." And M looked at her and said, "Ah yes, but my patient looks wonderful." (<i>laugh</i>) And they did, you know, and (<i>yeah</i>) and Y couldn't say anything because she was right, you know, so what she'd get time to clean up her bed area but her patient did, they were clean, they were comfortable, they were happy, and um, but they're the important things, um, yeah its little things like that happening (<i>yeah</i>) that are important. (2:7,14-31)</p> <p>At handover, the previous nurse had apologised to Asha for not finishing all the things that she should have done, Asha's view of the role of nursing and the memory of her colleague influenced her to be encouraging to the nurse she relieved at change of shift we should say to younger nurses, you know when when you come on and they say, "I'm sorry, I haven't done this, I haven't done that ra ra ra", I mean, to a degree I suppose, you have to teach and sort of</p>
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	<p>encourage people to do the best job they can if they're being that downright lazy, but there's certainly a place for saying, "Don't worry, don't worry, you know, the patient looks great, they're comfortable.." (2:7,7-14)</p> <p>Asha says I'm always really aware of the patient's comfort more than the machines alarming (2:1,36-37) Robyne is more specific in defining nursing as responsible for relieving pain different people have different needs depending on their background, and you're not in a position to judge whether that's appropriate, they're in a position to judge whether that's appropriate, and if they're experiencing it then that's real for them, and you're, you know, you can't judge that you just have to, um, help relieve the pain the best way that you can. (3:5,10-16) Comparing ICU to the wards, Taylor explains how the onus is now on her to be on the lookout for her patient's comfort I suppose now that I'm working in ITU that you don't you don't see.. people don't, people don't complain of of p' of being in pain (<i>Mm</i>) and now its up to us to assess them and if they're getting adequate pain relief and and if, um, you know, if they've got an infusion going, is that enough you're giving them, make sure, making sure they're comfortable if you're turning them or giving them boluses for procedures or (<i>Yeah</i>) you know. And you've got to assess that when you come on and see how, you know, how much pain they're in, or if that pain relief is holding them or (<i>Yeah</i>) So, it's a d'.. I find that it's a lot more n' nurse initiated in ITU than (<i>Yeah</i>) for the patient than other wards 'cause the patient on on a communicating ward would tell you that they're in pain or they'll scream or they won't get, you know, (<i>Yeah</i>) they won't move if they're in traction or stuff (9:8,29-9,7) someone on the, on the.. one of the wards, like it wasn't me, but they went to move someone and this person just hollowed, because, I don't know what they had, (<i>Yeah</i>) or they had a broken leg or whatever they had (<i>Yeah</i>) they they didn't give them any pain relief, I guess the per', the person that came on didn't know their history and didn't take, bother to (<i>Yeah</i>) see, you know, if they were requiring IM analgesia or whatever (9:10,10-17) I find it yeah, its more of a planning thing and a nurse initiated thing more so in ITU, (<i>Yeah</i>) than other wards because, you know, that on the wards people are screaming at you for pain relief (9:9,14-17) Leticia also is aware of this responsibility this patient can't tell you they're in pain so you the one that needs to be able to to look at them and recognise that they're grimacing and recognise that they're sort of moving towards a particular area of their body when you turn them or do something and what is it that they're responding to (1:5,15-19)</p> <p>Those of my colleagues focused on their patients' comfort decide to look for indicators of comfort levels.</p>
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<p>Goal Path: Attempt can only use your's and others' eyes causes outcome educated guess</p>	<p>In addition to those whose eyes have been redirected, others of my colleagues frequently look at the patient to see if they are comfortable. Bryce says you like to look after people, and and the best you can look after them is when you know what they want." Um, so when a person isn't capable of their own actions, you dep'pend very much on other people, including yourself, to try and interpret how how they're feeling, like their physical comfort and especially their pain issues (4:2,27-32) Leticia adds that assessment is difficult to do because you're using your, your ideas and the way you you think that person feels and putting them onto them and behaving accordingly (1:1,30-33) These nurses look for indicators of their patients' comfort level, but it depends on which eyes are looking as to what is seen. Petra so its sort of a mixture of what you've been taught and what you've experienced along the way. (10:4,33-35) Bryce thinks of patients he has looked after before you look at patients that you've looked after in the past and how they've reacted to similar situations, (Mm) and I guess, depending on where you've worked and what kind of patients you've worked with, I think you can often pick people who've worked with, um, say oncology patients especially, where they're on large dose (Mm) analgesia as compared to just the medical ward or something like that, where where people aren't as tolerant (Mm) of, um, narcotics especially, um. And you're talking about giving someone, um, oh I mean, just huge doses of say morphine or or or whatever to to try and, ah, quell pain, and you can see that a person who who's had that experience is quite willing to give a large dose but but on the other hand be cautious about giving a large dose and giving it to the person when they've they know that they they are in that pain enough to tolerate such a large dose. (4:9,5-20) Rhea says just you know the experiences with not that, particularly that kind of patient but, you know, with someone who you really want you know you really need to do chest physio with and um, or you need to mobilise and this day it gets forgotten, (Mm) you know the people need regular analgesia, you know, maybe post op, and you come along on your shift and you know, you sort of say "You haven't had anything all morning?" and you give them some analgesia and you know in about two hours later and they're just a different person (Mm) They're not miserable and you know its like "Oh, we'll go for that walk now or you know, "Could we do some exercise?" and things and you sort of think oh, just a couple of tablets and see what you can do, and then you give them a lecture about you know, "It's your responsibility to ask as well tell us, we're here to listen." (Yeah) Just things like that. But I mean, I mean, your best experiences are staying there, listening to people, (Yeah) and seeing different (8:16,28-17,8) I envy those who have had experiences in different IC Units because the treatments can vary (Yeah) so much and you can learn so much more (8:17,20-23) I mean, you get somebody with, you know, appendectomy,</p>
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he might come in and have a cardiac arrest, you don't know, but I mean what do you know about appendicectomies and abdominal surgical pain *(Yeah)* if you've never been anyway except in ICU and you know how to deal with the ventilators and the monitors *(Yeah)* what other experiences, do you learn? *(8:18,18-25)* Taylor pain is whatever the person says it is and you can't really assess someone's pain threshold or level if, you know, you don't think they look like they're in pain, they're only just saying that but, you know, *(Yeah, yeah)* But we were taught even those annoying patients who just keep, you know, going on and on *(Mm)* that, um, pain is whatever the person says it is *(9:7,30-36)* initially I learnt what pain was at uni and got an idea there and then I suppose through my pracs at uni you'd get out there and and see, oh you'd be doing all the elderly and and, you know, all the *(Yeah)* arth'arthritic pain and *(Yeah)* hip replacements and stuff and and um, and then since I've been working in.. initially I worked in psychiatry so I didn't see that much *(Yeah)* of phy', like physical pain, so then I started working at V this year I, um, just oh ori'.. I was I suppose I started on, I st' started on neuro then orthopaedics, so so I had the pain levels and then cardiothoracic so there were a lot of different units where people *(Yeah)* rely on pain relief especially orthopaedics *(9:8,6-18)* in cardiothoracic you still planned before you got them up day 2 for their shower *(Mm)* or whatever, *(Mm)* you're going to make sure you give them pain relief, you know, *(Yeah)* they're going to be in pain when they walk to the shower. *(Yeah)* But um, sometimes you get them.. and sometimes you just get to the thing, "Oh well, they haven't asked so it should be all right." So, I mean, *(Yeah)* and different patients and different things *(Yeah)* so.. *(They've got different levels)* Yeah *(and some people don't want it)* Yeah, yeah that's right *(Yeah)* and when you offer them, and then two minutes later they want it *(9:9,19-30)* I suppose that was again working on neuro but we we had a a long term patient that was there for like nine months, you know, and *(Mm)* just, you know, trachied peg-tubed, it was just the works just that and he was really a rotting away patient and he couldn't communicate at all, *(Yeah)* as in verbally, and um, every time you'd walk up to even say "hello" also he was schizophrenic, every time you'd walk up to do something to him or, you know, do pressure area care or whatever, he'd just, his eyes would just glare at you and as in I mean, he was terrified *(terrified)* of what you were just about to do to him *(Yeah)* and also he had a mental illness too, so, you know, you've got to see, um, *(Yeah)* are they being, you know, is other is the psychosis hitting in here too? But, and I mean honestly the look of *(terror)* sheer terror terrified every time the nurses, I suppose he'd been there that long and he knew that these things are painful. You know, *(Mm)* pressure area care is painful, *(Mm)* he was just rotting, *(Mm)* he was just but and skinny and, you know, and I just and yeah, he wasn't on *(He was laying there)* any infusion, no, no, and because he was long term, you know, and you were doing stuff every hour or

second hour or whatever you did, you know, *(Yeah)* got him out of bed and *(Yeah)* and physios saw him and you know, everyone wasn't giving him boluses, you know, *(Yeah)* PRN and he didn't have I don't think he had a drip in, I don't think he had a butterfly in so it would have been IM's *(Yeah)* so that people just didn't bother. *(Yeah)* And um, OK sure we didn't know if he was in pain at all, but just this look of terror every time you'd go to do something with him and *(Yeah)* if you just introduce yourself and try and go and say or explain what you're going to do but still it wouldn't go away like it would just be *(Yeah)* terrifying, I suppose he was had been there that long and knew that you know, it was just meant pain or, *(Ha)* you know, *(Yeah)* which is not a good thing but *(No, yeah)* so that was.. And also accompanied by a mental illness too like *(Yeah)* that doesn't help. *(Yeah)* I don't know, I suppose. (9:18,25-19,25) I think he was there for like that long that people thought "Oh well, we'd have to be, we touching him nearly every hour, you know, hour or two hours, we'd have to be giving him pain relief every *(Yeah)* second hourly and people just wouldn't *(Yeah)* you know, bother I suppose, like and he didn't, I don't think he had a drip in, he could have had a central line but, no I don't even think he had anything. *(Mm)* So people just weren't bothering and I remember he had huge big pressure areas like gapes in his bottom and we would just insist that, you know, we the doctors wouldn't write anything up we'd have to go and ask them, you know, before his dressings to.. we were giving him um, yeah something *(Mm)* and it was it would still he would still, you know, he would get st' *(Tense)* yeah, it was horrible and he would tense up then he'd have to have splints on and oh. *(Mm)* He was a, um, he was a rotting mess, *(Mm)* but he's not there any more, he went to another hospital. *(Yeah)* And all, and all that like with him being neuro and having mental illness, you know, *(Yeah)* I found that people just weren't giving him pain relief, I mean, *(Yeah)* he was just so long term that you'd have to be giving it, I suppose, all the time, which is, you know, maybe he needed to be on a morph infusion or something, you know, *(Yeah)* who knows, but and, you know, I suppose it's a busy ward and and, um, you haven't got time, you you can't communicate, he couldn't write he couldn't, you know, *(Mm)* it was just these eyes of terror that I'm sure *(Yeah)* that were, you know, weren't very nice but.. *(Yeah)* So I, we, I made sure we got him stuff like pre the dressings but other than that no, *(Yeah)* he didn't get anything. (9:19,30-20,22)

And it depends on how long you look, according to Asha I just think if you watched him, you could pick up *(Mm)* especially 'cause we had him for a long time (2:4,10-12)

<p>Attempt (i): assume awareness</p>	<p>Rhea Whether we can't see it or not, mentally they could be feeling all that (<i>Mm</i>) or should be (<i>Mm</i>) it just doesn't, we just don't stop it because they're unconscious (<i>Yeah</i>) and things like that (8:3,2-5) Asha sees her patient as possibly aware I don't know how aware they are of that though, so I guess we've got to assume they are (2:3,8-9) She bases this on a number of things, one being what she learned at a conference about the recall of a previous ICU patient, she wrote them a letter or went and saw them later or something like that and um, spoke about conversations she'd heard around the bedside from the nurses um, and things she'd felt, pain she'd felt, all this sort of thing (<i>Mm</i>) and she was there for a long time and I asked them in question.. you know, and they were sort of saying, "So be careful, you know, you don't know what the patients hear.", and certainly I go along with that, you know, I think you really have to do be careful (2:12,4-12) The other thing I asked them was , I said, you know, "The things she can remember", I said, "was that was she on midazolam or any sort of benzodiazepam?", and they said, "No, that was after she'd come off the midaz, she can't remember anything from the time she was on it." (<i>Mm</i>) which I think's important, you know (2:12,22-27) Leticia also has experienced patients remembering I remember the day she came back and um she said "I can't remember anything except M, the name M", and like she actually felt a bond with M just because she remembered his name. (<i>Laugh</i>) Because out of everything that had happened that was all that she could remember. She actually said she couldn't remember anything (<i>Yeah</i>) and I thought that was real interesting, but um just thinking about that, the guy that ended up down in iso with the pancreatitis, the um gentleman that didn't speak much English and he we thought he was going to die so many times. His name started with S. He was there, he was so sick, so long, and when um he was better and went to um, was going to the ward, a couple of times people um went down, JL, that's right, he said to her um, "Oh, you're the girl that did my nails, my toe nails.", and things that she thought he wouldn't 've remembered (<i>Cough</i>) but like he made comments about things that a couple of them were quite shocked about, but he remembered and he knew um, like he knew the physio and he knew um people that were sort of, like and like a physiotherapist is someone that's at them all day doing things to them and for them to actually, you know, (<i>Mm</i>) make a connection with them was obviously proves that repeated (<i>laugh</i>) (<i>laugh</i>) contact (<i>yeah</i>) you make an impact, (<i>Yeah</i>) and even though you may think you're not, but some of the things that he remembered were a little bit frightening (1:9,2-26) But Asha has experienced others not assuming patient awareness I heard one of the surgeons the other day say about a patient, now, I know that patient's not aware, you know he's had most of his frontal lobe removed, but he was saying, "Oh, I'm not saying that he's going to be any mental giant, I mean, just look at</p>
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	<p>him, you know, but I don't know if we should pull out on him.", and they were all just quite coldly talking about pulling out on this man (<i>Right over the top of him</i>) Right over the top of him (2:12,12-19) Petra if they're paralysed, um, you know that they're going to be feeling something underneath. (10:1,30-31)</p>
<p>Attempt (ii): assume pain or discomfort</p>	<p>Leticia sees all of these patients in pain I think pain is something that they all experience, and discomfort, um especially if they're an unconscious intubated patient(1:1,36-2,1) Asha agrees 'cause they still feel pain. That's the other thing, they just can't communicate it (2:2,23-24) Rhea I mean, they're uncomfortable as it is, so it doesn't have to be physical pain, but I know that that tube in your mouth (<i>Ah</i>) could be so uncomfortable (8:6,30-33)</p>
<p>Attempt (iii): age</p>	<p>Beth depending on their age too, 'cause I find sometimes really really old people don't have as much pain as.. that, that's most probably a bit debatable. (7:2,3-5) I don't know, but sometimes I find that really really old people don't seem to, but then that may be my reluctance to give really old people a lot of analgesia too. (<i>Yeah</i>) Yeah but even working at the M with the hip replacements and that I find that the very old ones sometimes don't need as much, but but I wouldn't you know, withhold it on those grounds, (7:2,21-27) Toni And seeing whether it actually works or doesn't work, and and even in paediatrics, um, when I used to work there we.. you can sort of see what works on kids and they have a total different perception of pain to adults, and just they're very individual (<i>Yeah</i>) you know, and its sort of um, kids are just so different and that's sort of.. and look, the way that children complain about pain is a lot different to adults and I think just sort of working in those different areas you sort of get a bit of an idea about how everybody seems to cope (6:8,20-29)</p>
<p>Attempt (iv): gender</p>	<p>Robyne you know what men are like when they're in pain but (laugh) and that's another assumption! (3:4,10-11)</p>
<p>Attempt (v): culture</p>	<p>Toni different cultural things as well (<i>Yeah</i>) its very evident (<i>Yeah</i>) yeah. (<i>The way its expressed and stuff</i>) Mm, you know, whereas, um, like some European people have no qualms about being quite loud and you know, really voicing their pain whereas some other people are more reserved or quite stoic and would never let you know that they're sort of in (<i>Mm</i>) lots of pain. (<i>Yeah. Mm, and that, y'you said earlier that that would probably come through even though they're tubed here, (Mm) like with their behaviour or whatever. (Mm) Mm (Yeah, I think um..)</i> So, sorry, ha, if you're a European person and you're thrashing around the bed you're going to get treated better. (laugh)) Better. (laugh) Yeah exactly. As unfortunately is, I mean, at least they're making you know that they're in pain (<i>Yes</i>) you know, like, 'cause you sort of think, "Well obviously, you know." Yeah, whereas, I.. like a lot of Asian people don't ever (<i>Mm</i>) sort of, um, acknowledge that they're in pain, they're quite reserved and, you know, quite stoic about things, (<i>Mm</i>) and also like, um, some sort of Arabic and Moslem people are just very loud and, you know, but that's just</p>

	<p>their culture which you have to take into account, but <i>(Yeah)</i> its sort of just different ways of coping I suppose. <i>(Yeah)</i> And even in childbirth and things a lot of people are different, <i>(Yeah)</i> you know, some people are really loud and some are very quiet. (6:8,29-9,19)</p>
<p>Attempt (vi): 'hospitalised' or 'institutionalised ,</p>	<p>Toni I don't know whether sort of socio-economic status plays any part in that or not. I don't.. that's sort of.. that that would be hard I think <i>(Yeah)</i> to ascertain whether it does or not. But I think like some people who, um, are used.. like long term, people who've had long recurrent problems, like, I don't know, chronic back pain or, um, other sorts of things where they've been hospitalised quite a lot, react to pain a lot different to people who've never been in hospital before <i>(Mm)</i> and they sort of, they know the system and they know what they want and, you know <i>(SNEEZE, excuse me)</i> that's like migraine sufferers, like long, chronic migraine sufferers <i>(Mm)</i> they sort of know how to work the system and, you know, they know exactly what they want and and they sort of have a different outlook on pain and demand a lot more than people who sort of come in and <i>(Mm)</i> don't really know what's available and those sorts of things <i>(Mm, what they have to get, go through to get it.)</i> Go through to get it, yeah. <i>(Yeah)</i> You know, whereas some people, like I've seen quite a, a few people, like pethidine addicts and things who just.. all they will do was want to come in and get their shot then they'd go, and that was just acceptable <i>(Mm)</i> 'cause that was what they used to do, whereas, um, you know, some people would stay at home at, to the very last point where they think, "I just can't stand it any more." <i>(Yeah)</i> then they'd come in, you know (6:9,25-10,11) we just had this one girl, she was just, only about twenty five. She was a pethidine addict and she'd been around all the surgeries and things and she had this special, um, thing from the government that she was allowed 30 ampoules of morphine, ah, pethidine a month from each GP's, 'cause they said she had adhesions and all those sorts of things, you know, <i>(Mm)</i> then once she'd used that up, she used to come to the emergency department, so of course, she'd use that up in the first week, 'cause she'd go twice a day and those sorts of things, first ten days or so, and so she she used to drive, come to the triage desk, you'd know it was her, she get seen by the doctor, written up, have it, and then she'd go. You'd used to make her try and stay for 4 hours but she never would. You couldn't forcibly <i>(Mm)</i> you know, and it didn't use to affect at all, so she'd just go out the front and jump in her car and drive. Oh, it was just unbelievable, and she kept just doing that all the time, you know, until she lost the plot one day and ended up in the psych ward, but <i>(Mm)</i> I just couldn't imagine it, <i>(Mm)</i> yeah. She was.. and that was just a total different.. oh she said she was in so much pain, so oh, uncomfortable and those sorts of things, and yet in the corner would be this little old man with his NOF and he wouldn't, you know, <i>(wouldn't whinge at all)</i> wouldn't make a noise, you know. (6:10,16-11,2)</p>

<p>Attempt (vii): physical signs</p>	<p>Most of my colleagues see hypertension and tachycardia as possible physiological signs of pain, but there are other confounding causes of these signs. Taylor initially you can look at their vital signs and see if if they're in pain, like if their blood pressure's going up or if their heart rate (9:2,19-21) Petra You're really looking at like their blood pressure and heart rate, they're the two things that can sort of indicate if they're uncomfortable but unable to express it. (<i>Mm hm</i>) Um, hyperventilation (10:1,35-2,1) you can always tell if you've been a bit heavy handed on the paralysis and not enough on the sedation, and (<i>Mm</i>) you can tell pretty quickly that, um, you know, with their blood pres.. mainly its just their blood pressure and their heart rate (10:4,29-33) Rhea you know tachycardia for un', any other unexplained reason, um, and a rise in blood pressure for any other unexplained reason that you can't think, (8:6,17-19) Beth I look for things like, oh, tachycardia (<i>Mm</i>) but then that could be a sign of bleeding too, so you can't just go on that. (7:2,5-7) Asha I always say, you know, if somebody gets tachycardiac and hypertensive and puts their pressures up, um, it might be something as simple as their uncomfortable, and sometimes just simply moving them (<i>Mm</i>) fixes it (2:3,26-30) Robyne If they become like really tachycardiac or hypertensive when you're turning too, you you know you start to think well, you know, what's going on here? (<i>Mm</i>) Pain, you know, that's like the first thing you think of when they come back from theatre. (3:3,21-25) Patrick I guess you've got the physiological indicators, um, you know, blood pressure and stuff like that (5:2,22-24) Toni cl'clinical signs, like if they're they're getting really tachycardiac when you turning them (6:2,1-2)</p>
<p>Attempt (viii): grimacing</p>	<p>Facial grimacing is seen as an obvious behavioural gauge of pain, although, this has been disputed by our medical colleagues in some circumstances. Beth when you're moving them, oh well, just for coughing and suctioning, you can see them grimacing, (<i>Yeah</i>) facial movements, you know the sort of expressions (7:2,10-13) Robyne goes by grimacing if, you know, they grimace, y'you know, I automatically interpret that as, you know, something's disturbing them, something's causing them discomfort or pain (3:2,6-9) if they're grimacing, that's probably the main factor (3:3,12-13) I must admit I tend to go on grimaces (<i>Yeah</i>) yeah, and they're pretty, mm, they're quite sort of out of it, I think, if they can't even grimace (3:6,4-6) I think you'd have to be like, you'd have to be in a very deep coma to not be able to grimace when you were in pain, (<i>Mm</i>) because patients that are even, y'you even apply painful stimulus to who aren't obeying and they're they have, and they're flexing or extending, those patients who like score very low on their coma scales, they still grimace when you do that type of thing, (<i>Mm</i>) so, yeah I do. If they're not grimacing, and maybe this is a wrong assumption, but maybe, you know, they're not they're not perceiving pain. (3:6,9-18) Toni I tend to judge, like if I'm turning them and things, you know, if they're grimacing or sort of, you know,</p>

	<p>ah, could appear uncomfortable you can sort of judge that they are in pain. (6:1,29-32) Taylor obviously gritting their teeth, they're in pain, if if if they can't communicate.(9:2,22-24)</p>
<p>Attempt (ix): body language</p>	<p>Bryce its body language, because that's as far as we can get most of (<i>Hm mm</i>) the majority of the time (4:4,30-31) Bryce thinks they could be intentional as well its almost like they're they're trying to get at you somehow, like like trying to pull their tube out, its like, (<i>laugh</i>) "I'll get this person I'm uncomfortable and I'll get him." (<i>laugh</i>) (<i>laugh</i>) so (<i>laugh</i>) um, so there's something else going on behind there, I think (<i>Yeah, they know what will get the quickest reaction out of you</i>). Yeah, yeah its I'll think its (<i>laugh</i>) I think we regress to a a or a almost a baby stage type thing, you you learn very quickly how to attract attention and the best way to attract attention is to go right for the centre of it. (<i>Yeah</i>) None of this pussy footing around or (<i>laugh</i>) its they they soon figure out what's the (<i>laugh</i>) the best way to extract (<i>laugh</i>) as much attention as would hopefully get their desired result. (4:5,7-19) Asha sees restlessness and attributes it to discomfort if he was uncomfortable, if he was just a bit off and was just fidgety from that (2:4,12-13) Bryce agrees if they're moving about a lot and trying to get comfortable themselves, then um, obviously we haven't put them the way they'd like to be, ah, we haven't give them, given them the relief that (<i>Hm mm</i>) perhaps they they really need. (4:4,36-5,4) You've still got to look at them again, and say, "OK, um, they they they appear and that, um, y'you observe the signs of (<i>Mm</i>) what the the the pain and discomfort, Ah, are they trying to make themselves comfortable? Are they are they wriggling around?" Ah, (<i>Mm</i>) yeah, er, ah sort of a degree of agitation that you need to settle down and ah, get this person (<i>Mm</i>) back to a level of sort of comfort. (4:12,24-30) I mean, there are those people that sort of wriggle around that aren't sort of, I mean yeah, (<i>yeah</i>) sort of really purposeful in any way (<i>yeah</i>) but but there's sort of a degree of agitation that you assume is associated with pain (<i>Yeah</i>) and discomfort (4:13,7-11) Beth sometimes patients that have been quite restless after surgery and they've had to, say they've been on the ventilator say like triple A's are very restless and they've been sedated a lot but you can still tell that they're in (<i>Mm</i>) pain just by when you're moving them (7:3,19-23) Rhea I would, 'cause looking at signs of agitation (8:6,16) I'm sure, you know, the agitation causes their ICP to go up and stuff, so you're titrating it to get them to where you want your limits (8:6,19-21) moving their limbs, irritably reaching for tubes and stuff, (8:6,29-30) that type of patient can't say I've got pain (<i>Yeah</i>) but you know they're telling you because of their agitation or they're (<i>Yeah</i>) moving around (8:9,36-10,1) you automatically know that if they're starting to get restless and irritated and you know that they're its probably pain (<i>Yeah</i>) or discomfort from the tube, or discomfort in the bed. Change the position or whatever (8:10,8-12) so in a way you sort of</p>

	<p>look at that as that as their way of telling you bar all that writing, <i>(Yeah)</i> pointing, <i>(Yeah)</i> telling you. (8:10,19-21)</p> <p>Beth sometimes when you're moving them if they get stiff, you know, all tensed up, you know, <i>(Yeah)</i> all stiff stiff, <i>(Laugh)</i> <i>(Laugh)</i> um, they tense up, that's a sign of pain (7:2,8-10) even though somebody may say that they're not in pain you know as soon as you go to move them that they are because they go as stiff as a book with anything <i>(Yeah)</i> and make no effort to cough and things like that <i>(Yeah)</i> but you know that if somebody tenses up that they are in pain (7:3,1-7) Bryce sees tension as indicative of discomfort you often find y'you'll go to to roll the person something, they'll be very very tense (4:3,12-13) when they encounter something as stressful as what being tubed and so forth and and we us having literally total control over their body <i>(Mm)</i> and what we want to do with that body, how we want to manipulate that, um, they get very tense, so, which is a physical and comfort, pain issue. (4:3,17-21) y'you can I'll think you can actually feel it in in their muscles if they're nice and flaccid then you think, "This person's nicely relaxed." <i>(Hm mm)</i> They, as far as we can tell, we, they haven't got any physical pain <i>(Hm mm)</i> that's making them tense and rigid and trying to guard this pain (4:4,31-36) Taylor or if they're tense or or red face (9:2,21-22)</p>
Attempt (x): clammy	<p>Beth sometimes when your in.. they're in pain they get a bit clammy. (7:2,14-15) sweating, you know, you often see people are a bit sweaty when they are in pain (7:8-9) Rhea they might not be able to move at all but then they have this huge sweat and if its not for an unexplained, for any other reason, then <i>(Yeah)</i> you've got to consider the fact that it could be <i>(Yeah)</i> its irri' irritated or, you know, in pain. (8:6,36-7,3) they sweat <i>(Yeah)</i> even when they're paralysed. (8:7,10-11)</p>
Attempt (xi): Pupils	<p>Beth I suppose pupils size sometimes <i>(Mm)</i> could be a bit of an indication too. <i>(Mm)</i> Especially in somebody like this who is unconscious. <i>(Yeah)</i> If they're large they could be in pain. <i>(Yeah)</i> but also frightened too <i>(Yeah)</i> so may need to be given a bit more sedation (7:3,10-14)</p>
Attempt (xii): nociception	<p>Petra just a patient that is unable to respond <i>(Mm hm)</i> due to um, pathology, that could be another indication. <i>(Mm)</i> Um I think you have to always assume that, or like look at their actual underlying pathology and in most cases assume that they will have some degree of pain and discomfort um, even just from being in this sort of situation. (10:2,29-34) being confined to a small space, being turned every two hours, being wakened up every five minutes. <i>(Mm)</i> Having things jabbed into them, tubes, like whatever tubes, whether its ET's or NG's or catheters or whatever <i>(Mm)</i> and just, you know, so even lots of tape and stuff all over them's going to make them uncomfortable. (10:3,2-7) if they've got a huge surgical wound then the chances are they're going to have pain, <i>(Yeah)</i> they've got a big subdural haemorrhage <i>(laugh)</i> then unless its too big we'd have knocked off their pain centres as well. But, um, you know blood in</p>

your subarachnoid space is going to cause pain like that sort of thing. (10,4:8-14) **Leticia** thinking about how much pain the type of procedure that they've had would cause them. (1:13,18-19) **Rhea** I've had abdominal surgery and I know, you go to take a deep breath its sore, you cough its sore, you laugh its sore (*Yeah*) you know, so, and that's just, it takes days to wear off and because we have the majority of people in the acute stage I think its important to be aware of (8:4,33-37) I've worked in surgical ward for a long time as well um, and any post op patient has, any surgical incision has pain attached to it (*Yeah*) um, in particular er, you've got to think of where the incision is as well as to how the continuum of pain (*Mm*) I mean, obviously, if its something like a hip replacement they're going to have pain when you roll them on that side initially but um, the main majority of pain is going to be when you start to mobilise. Well, we don't do that (*Yeah*) but you've still got to consider we have them at the acute phase (*Yeah*) so I mean, if they are with us for may be nine or ten days because of a chest problem and can't go to the ward you're not looking at surgical pain and that's from experience that you learn that (*Yeah*) and listening to other patients with different conditions. (*Yeah*) Its not something you just know (*Yeah*) its listening to other people. (8:4,9-25) obviously, if they're, it depends what they've had, I mean if they're, if you, if they've got a condition which would obviously have pain connected, you know, often after surgery, (*Yeah*) that they just can't tell you. You know, its got to be painful. They're going to, you know, come around from the anaesthetic at some point or if its three days down the lane and you know that its not going to be (*Mm*) something that just goes away. You know surgical incisions, it takes maybe a week for the pain to die down, especially if it's a huge one or if it's a thorocotomy, you know things like you've got to think about how they're being supported like if they're being ventilated and they have got a thorocotomy wound, they've got chest drains, its naturally, that its going to be painful. (8:2,25-3,2) if you fall and hurt yourself you know you've got this amount of pain and you know why, but you've got a surgical incision, you sort of like its different (*Mm*) I mean, I haven't broken any bones or anything like that I mean I can't imagine, (8:5,32-36) P had a huge abdominal dressing (*Yeah, yeah*) um, and I know I personally did that dressing and got no reaction out of him (*Yeah*) and I felt that he wasn't experiencing any pain because I could, there was nothing (*Yeah, that's what I was..*) there was no physical signs or ..(8:12,25-30) (*there's no show of anything when you do the dressing, but when he was turned (Yeah) the girls said he had a grimace, so if he was written up for something then, like, I couldn't understand why the next day he was written up for something before dressing but not before procedures like not before turning, (Um) that's when it was indicated that like.*) Like it was obviously just not thought about. (*Yeah*) It was just oh well, you know this soothes our conscience. You know, it should be before, he should be

	<p>experiencing pain during the dressings (<i>mostly for a dressing</i>) so that's what we'll do rather than assessing what he's actually doing. (8:12,34-13,9) Toni if the people have had some major type of surgery, y'you can, you obviously think, "Well they probably will be in pain." (<i>Mm</i>) Um, you know, some big procedure or something (6:2,7-10) I mean, he's got a huge abdominal wound, and obviously he he must be in pain, (<i>Mm</i>) well I would assume he would be. (6:14,16-17) Robyne thinks of what would be causing the patients pain the type of surgery or, um, you know, their disease process, for example, if you've got, um, a person that's been in a car accident with multiple fractures, you know, there's an assumption that they are going to be in a lot of pain and if they're not doing anything, you know, you would give them a bolus before you moved them or do any procedures (3:2,1-6) Especially if the patient is paralysed, Robyne sees the nature of the injury. (<i>Right</i>) So if its extensive surgery, (<i>Mm</i>) and ah, yeah extensive surgery, fractures, long operative procedures (3:8,32-34) as possibly causing pain. Bryce compares other injuries he has seen in awake patients if someone's broken their leg you think it'd be painful, nup I've never seen, I've never given the amount of pain relief that, for that as I've given (<i>Mm</i>) for renal colic because ah but well I think that that was one situation where different pain has a different pain, and people subjectively think a broken leg's worse, but its not. (4:21,27-33) Patrick when they have huge dressings and stuff like that you sort of go, "Yeah, they must be in a little bit of pain or something." (5:15,20-22) Taylor if you're new and you haven't got much experience and you haven't done that, like I haven't done much, many oesophaguses, (<i>Yeah</i>) the two or three that I've done now, when I've looked after have been extremely painful (<i>Mm</i>) you know, and um, so a' that's what's in your system to go on, like that type of surgery must be very painful, especially for suctioning and (<i>Yeah, yeah</i>) so, yeah, and if you haven't dealt with the proced', that type of surgery before you don't know (<i>No</i>) other than the obvious (<i>Yeah pain yeah</i>) how that person's pain is during (<i>Mm</i>) procedures and (<i>Yeah</i>) (9:22,21-31)</p>
<p>Attempt (xiii): acute or chronic</p>	<p>Toni when I used to work in emergency, people normally came in in a very acute phase, (<i>Mm</i>) and um, then in contrast, you always get your chronic, long term back pain and those sorts of things, (<i>Mm</i>) and I think, just being able to, um, you know, recognise, what this person's obviously in, you know, acute pain and see what type of analgesia works compared to sort of chronic long term people and when we used to get oncology patients in you could sort of see the huge doses they used to get at home and then you know that obviously its not working when they still come in and (<i>Mm</i>) (...) in pain and uncomfortable so.. I think just sort of getting quite a broad look at different ways people manage pain (6:7,29-8,3) Bryce sees acute and chronic pain as different I mean, then you've got to look at it, is it acute or chronic pain</p>

	<p>because there's a big difference on how to manage acute and chronic pain. (Mm) So, I mean, chronic, y'you're starting to look at sort of larger doses again, and and the use of alternatives especially, whereas acute pain is mainly sort of directed at plain narcotics and maybe a little bit of relaxation. (Mm) So um, yeah you've got to look at how how long that pain's there for (4:11,29-36) I guess its d', hard to determine um, the longer term patients that um, get unwell, OK they're unwell to begin with, but they get (Worse).. their condition worsens, um, what kind of pain are they in now? (Mm) OK they're over their acute stage of their.. someone sort of slicing open their abdomen, but what, what sort of type of pain are they in now? (Mm) I mean that's that's a difficult thing to try try and comprehend I think. (Mm) I think sometimes patients go beyond the scope of our imagination and experience (Mm) um, I just.. because yeah, I mean nearly, I guess, hopefully everyone.. all the nurses there are are well enough not to have experienced.. OK they may have had a big operation but have they gone into renal failure and have they gone into multi multi system organ failure, what kind of pain is that? (Mm) Um, is there a pain, I mean, there's got to be pain with it, (Mm) but is it, is it a real sharp pain, is it a dull pain how how do we best get rid of that? (Mm) Do they need, I mean, how how do we wean their their infusion down to to a level that's keeping s' general body pain not the specific, um, incisional pain? (4:12,3-22)</p>
<p>Attempt (xiv): individuality</p>	<p>Bryce tempers this option with the fact that patients are still individual in their response she she was having a lot of pain just with the cannula site. But, say, as compared to an orthopaedic injury that may be, only minimal, but to her that was a large issue (4:2,32-35) Taylor I don't know if that's a good thing because that person's another individual (Yeah) that mightn't feel the pain or, you know, might have different levels of pain, so (Yeah) still, I think you've, I I'm not saying I probably would do that but but you've still got to assess the individual as as their (Yeah) pain. But yeah I, you know, I definitely would, now I've done that procedure before and that was, that person was in (Yeah) tremendous pain so this person would have to be in a bit of pain (Yeah), I'd at least think like that. (9:22,7-16) Toni I think everybody's perception of pain's different as well, and just some patients, like if even though the person might be ventilated, then if they're quite a stoic person, they mightn't be displaying that they're in pain either, and probably wouldn't normally have told you anyway that they were in pain. (6:1,32-37) pain and things is is very individual, (Mm) and I think we tend to forget that, like some people might have a procedure which we would consider as being quite minor, yet to that person it's a big deal and they're in lots of pain (6:22,29-32) Bryce just people don't differ.. they tolerate (Mm) differently, ah yeah with the pain's different for that person too. (4:21,22-24) However, Bryce thinks patients with similar tissue damage need similar amounts of analgesia (if you had two triple A's do you think they would have about the same amount of morphine?) Quite similar, yeah, (yeah) I I think, in comparison,</p>

	<p>relative comparison, um, you, in say in terms of mgs per per kg of body mass (<i>Mm</i>) or something (<i>Mm</i>) like that, um, I think in comparison people are generally ah, the sort of staff are generally sort of like yep that's acceptable amount to give that person and they now appear to be quite settled (<i>Mm</i>) and um, and pain free, so (<i>Yeah, you still go on what they look like, that's really the bottom line</i>) <i>Yeah</i> (4:22,7-17) Rhea they can tell you and you can sort of try to imagi' I don't think you can imagine someone's amount of pain. As you say, I mean, I have worked closely with the guys who set up PCA system in the last hospital I worked in (<i>Ah ha</i>) and our big thing was no matter what you think, the patient's pain is what they tell you it is. (<i>Yeah</i>) and you can't change that, I mean you're not there, you're not experiencing that, you don't know (<i>Yeah, yeah, its hard to imagine what their pain is when you can't..</i>) you can't, you can't put yourself in somebody's shoes unless you've been there (<i>Yeah, if you</i>) and even then its individual (8:5,4-16) it give you an insight (<i>Mm</i>) um, but not necessarily, because everybody's level and their, I mean my, I was, I I think I was pretty good, I mean, I was up and around (<i>Mm</i>) not so long after the operation and stuff like that. But you see other people and they can't, and and I think more of my understanding would be listening to other people out there (<i>Yeah</i>) other people than from my.. (<i>Yeah</i>) it just gives you a better insight than someone who's never experienced surgical pain.(8:5,21-29) everybody's level is different so, I mean, what I have if you would have it mightn't be exactly the same. (<i>Yeah</i>) 'Cause I mean I know at the time when I was in hospital, there was two other girls had the same procedure and I had been discharged two days before either of them, um, and we all came back at the same time to have sutures removed, and one of them was still hobbling around (<i>Ah, yeah</i>) so its just everybody's pain perception (<i>Yeah</i>) that I mean, that just highlights it.(8:5,37-6,9) Taylor I was just pumping just, you know, pain relief and analgesia all the time and, um, you you really find it.. sometimes you get really annoyed that you know these people.. you you've given them so much and (<i>Yeah</i>) still its not, as you say, it would hold d', it would hold different people. (<i>Mm</i>) Different levels would hold different people and you would just think, "Oh, surely this is, you know", (<i>ha ha, yeah</i>) you know, they just keep going on and on and on and obviously it wasn't holding their pain (9:8,18-27)</p>
<p>Attempt (xv): relatives</p>	<p>Bryce is aware of the fact that those people close to the patient know them as a person and can help in the interpretation of signs you often find the family'll tell you what a person is like (4:3,11) I mean, spouses would be the closest, I mean (<i>Mm</i>) if they're sleeping with them every night in a double bed then, and if they've been sleeping there, I mean especially an elderly person, say for the last thirty years, then, um, you've got someone who knows this person back to front. (4:3,30-34) Bryce also looks to sees if the patient responds to the family at all I think you'd start to to look at family and how how perhaps that person is, um, responding to that (4:7,4-5) Taylor its also also hard</p>

	<p>like if the relatives come in and and and they.. I don't suppose that they don't know that.. they're not a'aware of the environment and and they might think they're in pain and they probably know the person better than we do anyway (Mm) and might, I don't know, sometimes by talking to the relatives you can pick up a a a, you know, little things but, um, just.. (9:3,4-10)</p>
<p>(but) outcome: clean and presentable patient for relatives to see</p>	<p>Patrick And, that's why yeah, I guess you always like to have, I guess its something I've thought of and feel that maybe we're sort of delaying the, um, the time between the patient arriving and the actually letting the relatives in, um, for the relative's sake, to, (Mm) you know, have have the patient nice and comfortable and pain free and clean sheet and (Yeah) and I think that's one, another one of those things where we just take a guess, because I think sometimes that is good for them and other times people just prefer to come in and no matter what. (People are sitting out in the waiting room (Yeah) biting their nails, (laugh)) (laugh) I know, its like errr!! (laugh) (Let me in the door. (Mm) Yeah.) And that sort of thing doesn't it, I know we're sort of getting off the topic but, doesn't it it brings it home, no'no'nothing brings it home better than than having to sit in a waiting ro'room yourself in another hospital (Yeah) in intensive care, its like Mmm (laugh) (5:20,31-21,17)</p>
<p>Attempt (xvi): imagining self as patient</p>	<p>Beth things I look for? (Yeah) Yeah (Yeah) OK, things.. well, most probably I then think, "Would I be in pain in this situation?" (7:1,37-2,2) Asha vividly sees what it would be like for herself to be the patient But it would be important if it was you and you know, your leg was in one position and it was sore (2:2,22-23) things like peri care and mouth care, can you imagine what it would be like to have all this saliva at the back of you throat and not be able to swallow it, it'd be just so uncomfortable (2:2,36-3,2) or if you've got thrush, having an itchy perineum, it'd, that would override any discomfort with an ET tube, I think, I mean, really that'd just be horrendous, or, feeling, just feeling dirty I th'..is another thing, you know, if um, if you felt you were sweaty or dirty or, you know, you felt you were smelly (2:3,3-8) putting yourself in their shoes, um, yeah and as I say just little things like being on one hip for too long and.. Looking at somebody's position is another thing. Like looking at them, when, you know, when you position them on their side and their head's bent right forward and their arm's right over like this, I mean you wouldn't be comfortable yourself if you were like that (2:3,16-23) Robyne also visualises herself as the patient I often sort of try and place myself in their position, and I think of the.. even if they're not.. there must be some element of discomfort having all those tubes in, (Yeah) and every time you move it pulls a little bit, and there's that noise, and there's like, you know, that total.. I'd be totally irritated by the environment, and that, you know, I mean, maybe that accounts too for a l' a certain amount of pain (3:3,2-8) Bryce I think you've definitely got to try and put yourself there (Mm) to see, y'you look at the person look at how they're ah, at how they're reacting and thinking,</p>

	<p>"How would I be reacting if I was lying like that, if I had this injury how would I like to lie." (4:5,31-35) y'you sort of try and put yourself back into their situation (Mm) again. You look at them (Mm) and and it's a it's a, um, its an assessment, an examination, and its not like, "OK we're going to sit down for ten minutes and assess this person." (Mm) its more of a, "Look at this person. OK, so I'm gonna say, he's um, he's had a major operation, abdo operation how would how do you think I would be feeling? Well, well, my stomach would be pretty well churning at this time. I l'd want to be pretty bombed out for the first day or two, so l.. to get over this initial, real bad pain and then try and wean it down after that. OK I might be a bit bombed out and a bit spaced out, (Yeah)(cough) but I think I'd rather be bomb bombed out and, ah, and not feeling that because that that's not going to be of benefit to me." (No) So ah, um, yeah it's it's put put yourself in their shoes, do do you think that they.. do they deserve to be put through that? OK, it's it was their.. they volunteered, they were accepting, ah, they knew the consequences of pain and so forth associated with say an operation, but it doesn't mean they necessarily deserve the pain (Mm) that is encountered afterwards. (4:7,31-8,15) Patrick specifically thinks of suctioning an endotracheal tube Well, your airway'd be so inflamed, and with, like coughing while you've got a, (Yeah) you know, you've got a brand new cold, I guess, (Yeah) and you can't breath in air. (5:5,27-30) and post surgery I mean yeah OK you have sutures and then sort of the sutures inside of you and sort of like sort of sudden different pull in a different direction and (Yeah) and you've got these three drains inside of you and sort of you're turned and they scrape around in there. (5:15,32-16,2)</p>
<p>Attempt (xvii): gut feelings</p>	<p>Beth I suppose probably just the, an instinct you get, (Yeah) yeah (Sort of gut feeling) yeah, there and it most probably is more an association of the conditions that they're in and would I be feeling pain in that situation. (7:2,16-19) When Bryce is unable to see indications of comfort I guess there are those that, um, can't move at all. (yeah) Um, mm, that's ah, that's a very, ah, it's a feeling one I think its not a looking one, um, (and you've got to go on your feelings) you've got to, you've got to try and start to, um, look at, um, yes subjunc subjective feelings, ah.. (4:13,11-16) I think there is a gut feeling, (Yeah) ah, and everyone'll say go with your gut gut yeah instincts, (Yeah) um, because more than often y'you correct in those instincts. (4:14,1-3) Toni they just look very uncomfortable or.. yeah, its its hard, I don't know how l.. (how you do it) mm. (Mm) I think sometimes you can just, you can just tell if you patient's in pain or not. (Mm, just like a gut feeling sort of) Yeah, (Yeah) just sort of like a gut feeling (6:2,3-7)</p>
<p>Attempt (xviii): advice – looking through other's eyes</p>	<p>And just asking people when you're not sure, "Do you think I should give this do you think I should give that?" (1:7,24-26) Patrick you know, how you're sort of sometimes you're on nights and you sort of say, "This patient just does not</p>

	<p>look comfortable.” And or like, you know, you ask people, “What else can I do?”, or like people say to you, “Oh, I just can’t get this person comfortable, he just doesn’t look comfortable.” (5:24,4-9) Bryce finds variations in advice and attributes this to different gut feelings if you ask someone’s opinion too, um, some people.. there can be a difference like three or four, um, mls an hour which is (<i>laugh</i>) which is a fair bit, I mean, that’s a lot of.. I mean, when you consider it over say (<i>24 hours</i>) I mean even two two mls over 24 hours I mean that that’s 48 mgs (<i>Mm</i>) of something, um, that that’s a lot of of relief, um. (<i>yeah</i>) Um so but that’s subjective, (<i>Yeah</i>) um, obviously that person either feels that, “No, he hasn’t got any pain.” Or “God, he must be in a lot of pain with that.” (4:13,24-32) if you had the one patient and s’ got four people that were on that afternoon, I I re I’d lay a bet that you could a range of say.. if it was sitting there on say five and said, “Do you think he needs more or do you think he needs less?” and if you put a case down, the exact same case to each person, I think you could go from say about, a low of about three, one person saying, “No, I think you could start to wean it down a bit.”, (<i>Mm</i>) um, whereas a person may say, “No, keep it as it is, that’s fine.” And another person saying “No, I I think I’d increase it one or two just to see how it goes.” (4:14,6-16) Rhea we’re using other, we’re we’re playing on other people’s experience like the intensivists (<i>Yeah</i>) to give us guidelines, (8:7,20-22)</p>
<p>All these attempts take time</p>	<p>although it sometimes takes Leticia more than an hour at the beginning of her shift to see her patient’s response to different situations after my first initial hour or so with them and I can see that that’s distressing for them, um, when they’re being turned or, um, suctioned then I’ll give them a bolus before I treat them if that’s a, you know, their haemodynamic status allows that (1:3,33-37)</p>
<p>Outcome 1(a): difficult, unsure, educated guess</p>	<p>Petra if they’re not capable of purposeful actions its very difficult (10:3,35-36) Patrick its just so difficult to assess I think (5:2,22) its like “Oh, look, I’m just doing your dressing here,” and its like and your abdomen is right open, you know, “Is is that painful at all?” and “You’re not just giving me any,..” um. (5:7,27-30) Bryce If you can get some feedback it’s good, but its very difficult on the upper half, on our side to try and ah, yeah, interpret that pain. (<i>Mm, on the people that don’t give you feedback</i>) Yeah, when you can’t get feedback (4:3,1-5) it’s a difficult area because you can’t get a person’s verbal responses (<i>Mm</i>) often, um, and I guess there’s never gonna going to be a, er, a way whereby we can truly assess it, I mean, if you you think of the definition of pain, and think it.. I mean, it’s a subjective (<i>Mm</i>) feeling that that person expresses, um, which is interrelated with all their all their cultural and learnt values and and so forth so, we’re never gonna be able to subjectively, (<i>Mm</i>) ah well, I mean, objectively actually evaluate someone’s pain to.. I mean, if I break my arm as compared to you breaking your arm in exactly the same space spot, (<i>Mm</i>) whose is the most painful? I mean, (<i>Yeah</i>) is it mine or is it yours? Its..</p>

	<p>and maybe its mine because I tripped over my rose bush and broke that, or is it yours because you (laugh) (<i>laugh</i>)(4:7,13-27) Toni its very difficult to ascertain whether they're actually in pain or not. (6:1,25-26) But really sometimes you can't also see that much either. (<i>Yeah</i>) You know, like if you've got them sort of heavily sedated or.. with um, lots of morph and things, I mean, you're not sure (6:2,23-26) Rhea I'm not a hundred percent sure (<i>laugh</i>) to be honest (8:6,15) you don't know (<i>Yeah</i>) I think it is pretty hit and miss. Um. (<i>Yeah</i>) I mean, if its all for unexplained reasons and nothing else that's one thing that you'd consider (8:7,12-15) Um, in those in those type of patients that can't tell you? (<i>Yeah</i>) (4 sec pause) Its hard to know. (8:16,2-3)</p>
<p>(but you can live with being unsure until you have to write it down) documentation</p>	<p>As Leticia fills in her observations on the paperwork, what she sees the patient doing doesn't fit with the available categories on the pain and sedation chart I realised that those categories are are fairly inadequate when, for example, the the patient that I looked after last night was a head injury who could move her left side but wasn't conscious and was quite purposeful with her left side and would have extubated herself yet she seemed distressed and it was difficult to know whether she was awake or un..un..um some sort of level of unconsciousness and whether or not she was in pain or she was in d,discomfort it was fairly difficult, and then when you had to write that on a chart, (<i>Mm</i>) was she awake or was she drowsy or was she unrousable? I found that really difficult to to categorise her (1:2, 24-35) you can have lots of experience, it can be quite difficult still to actually categorise what the patient's experiencing and where they're at (1:2,35-3,2) And just having had a look at a couple of the charts in the last week, I think they're really poorly filled out. (1:4,23-24)</p>
<p>Outcome 1(b): discredited</p>	<p>Toni finds the doctors don't listen to what she sees I think um, at times they don't really, um, take into account that you've been there all the time, like I think that they should actually try and discuss with you how the patient's been going, 'cause, (<i>Mm</i>) you know, they just come along and say, "Well we'd better stop the, you know, the sedation or stop the analgesia or decrease it or something. " You say, and then if you could, if they would just listen to you a bit more I think, (<i>Mm</i>) 'cause you've been there all day and you know how your patient is and (<i>and why</i>) and (<i>why you've got them to that state at that time</i>) to that point, time, yeah. (<i>Yeah, what's happened just before</i>) Yeah, exactly, so I think um, (<i>Yeah</i>) I think as nurses we're not often, sort of given enough credit for (<i>Mm</i>) being able to ascertain how uncomfortable your patient is or how they're too comfortable or whether they're getting too much pain relief or not enough. (6:6,33-7,10)</p>
<p><u>Episode 2:</u> Beginning event: patients' comfort is unknown</p>	<p>Some nurses don't think about comfort, others believe its their job to provide comfort, the patients aren't able to clearly communicate what they are experiencing and they need all sorts of care just to keep them alive.</p>

<p>Simple reaction (2) believe patients should receive individualised quality care causes goal: provide comfort as best these nurses can</p>	<p>Bryce thinks all patients deserve individualised quality care everyone deserves a a degree of pain relief that is satisfact satisfactory to them, (<i>Yeah</i>) um, not satis not as satis satisfactory for us, satisfactory for us so as to ah, not to affect them (<i>Mm</i>) in any sort of physical way, ah, but yes satis satisfactory for them. (4:8,31-36)</p>
<p>Goal Path: Attempt do activities that promote comfort causes outcome unsure of patients' comfort</p>	<p>Leticia thinks that experienced nurses manage pain better its something that, um, you can only manage well when you've had lots of experience at doing it (1:2,2-3) although she is not totally sure of her skill in this area I can now, um, look at a patient and and see, fairly confidently, whether or not their analgesia and sedation is adequate (1:2, 13-15) Asha divides the areas of medical and nursing responsibility You know, of course when you talk about pharmacological treatment that's a medical thing. (<i>Mm</i>) Certainly we're the advocates and we can bring it to their attention, but as I was saying earlier, there's other things I think that we can do from a comfort point of view (2:15,11-16) Rhea doesn't know how much help little things she defines as non-nursing can have for these patients but the smallest little thing totally non-nursing related (<i>Yeah</i>) can make such a big difference. (<i>Yeah, yeah,</i>) um, but in our situation I don't know if its relevant.(8:25,33-36)</p>
<p>Attempt (i): narcotics</p>	<p>Petra generally patients that are paralysed or um acute anyway their pain seems to be quite well managed. (<i>Yeah</i>) Um, well from like a medical order side, and then its up to the individual nurse to to fulfil the order (10:5,9-12) Patrick I think that.. and those people who will be.. will always have a, like a morphine and midazolam infusion up anyway (5:2,7-9) Leticia is unsure of the goal of analgesia the difficulty with that is at the time you suction someone they might have abdominal pain because they've had surgery and yet in between times they don't move and their completely comfortable, so do you titrate their infusion for the time that they're being treated or do you, um, cope, you know, do you aim your management at in-between times (1:3,22-28) Leticia aims to keep her patient comfortable rather than completely pain free (1:3,18-19) I think I tend give them a general level of comfort that they appear to be almost pain free (1:3,32-33) try and minimise the the pain for them during the procedures (1:4,1-2) Bryce is clear when it comes to the aim of analgesia you've got to get rid of pain there and then (<i>Mm</i>) its not a matter of saying "Let's wait and see." (<i>Yeah</i>) Um, because that doesn't do any good for the for the patient (<i>Mm</i>) um, so you've got to get rid of it then and not later (<i>Mm</i>) because the idea of pain management is to manage that pain adequately, its not, "Oh, let's wait and see." (<i>laugh</i>) that's not managing, that's, um, that's being um, what would you term its, its</p>

	<p><i>(like um)</i> that's being mean <i>(yes, laugh)</i> yes, it is, its torturing someone (4:17,28-36) but that the pain isn't hasn't gone. <i>(Mm)</i> Um, that's and that's what its aiming to do. <i>(Mm)</i> Um, but if, if you find you're not achieving the effect and you've got to find somewhere some some other way, um, because.. and I think sometimes we depend too much on sole.. um, people get stuck in a rut of morphine as the only <i>(Yeah)</i> um, form of pain relief, <i>(Yeah)</i> um, because often you'll find, yeah some some pain relief works better for others whether it be a psychological thing, I think some people react differently to different blends of <i>(Yeah)</i> things (4:10,27-36) Robyne is unsure where to aim her care because she is unsure where the patient is at you don't want to oversedate them, y'you know, you don't want them to be there in pain, so, you know, it's a bit hard to know when exactly, you know, <i>(what?)</i> what's too much, what's too less <i>(yeah, yeah)</i> when you not getting any feedback. <i>(yeah)</i> I suppose that's the main the main problem (3:1,31-35)</p>
(a) hesitant	<p>Beth some people are really reluctant to <i>(Mm)</i> give it (7:5,17) the other problem I suppose is when they are hypotensive, people are often very reluctant <i>(Yeah, because it drops it more)</i> (Keeps it more, yeah) <i>(Yeah)</i> and I often find that a bit hard. (7:8,13-17) Bryce I guess pain relief <i>(Mm)</i> is a big thing, um, and I think m'may be o'off the track a little bit but, um, I think some nurses.. there there's.. its something I guess that's relatively new sort of phenomenon in terms of pain relief and providing adequate pain relief, um, there's always that notion that we're.. er sitting in the back of our minds, um, that we're going to give too much, <i>(Mm)</i> um, and I I guess we sort of lag back and then and we don't give enough then, um, I think there's a fairly wide scope of.. th'the a large medium that we can work in, I I think w'we think its so so fine a line <i>(Mm)</i> that um, if you overstep that line, w'we're definitely over the, over the cliff, but I I think there's a lot lot more distance <i>(Mm)</i> from t we can.. we get to the edge, so ah. (4:6,23-35) but some people, I think, are a little more cautious than others, I think that's how you term it, I don't think there's a.. um, it's a it's a un unwillingness and and a cautiousness to to give that if they're not as experienced in that sort of area <i>(Mm)</i> of pain management <i>(Yeah)</i> and ah yeah, comfort management. (4:10,4-9) Patrick in an intensive care setting I think there's been times where I've given far too much, and, you know, more experienced people come sort of offer me and sort of um um they sort of say, "The pupils are a bit small here. (laugh) <i>(laugh)</i> Maybe we should turn this down from ten maybe to five at this point," (5:8,11-16) I think because, I don't know, I think we were trying to wean overnight or something I don't know, and or was it, um, um simply pupils were constricted and and just sort of felt that they'd been given a bit much and it wouldn't be long before he would be like wake up or something <i>(Mm)</i> or her to wake up, I can't remember what it was. <i>(Mm)</i> I mean, I can't quite remember the circumstances, I sort of at this time saying, "Yeah you're right." (5:16,12-19) I think, the only time I</p>

	<p>would just sort of wean it off my own, um, on my own accord is if like blood pressure was too low, um, or um, yeah, we're going to extubate the patient and and so, um, I felt that you know, we'd try and get them to breathe up a little bit more and um, yeah, I just felt that we could probably achieve the same with a little bit less, <i>(Mm)</i> and um, just sort of yeah, not sort of challenge them too much not metabolize too much of the stuff <i>(Mm)</i> because I mean, I guess one thing we don't sort of, um, consider either is um, um, and I think that there's probably a lot more research again needs to be going into that as well (5:16,25-17,1) Taylor my patient overnight I kept the rate the same and just gave a couple of boluses <i>(Yeah)</i> and it was a quite big rate but I left, I left it like that <i>(Yeah)</i> and just gave I think one bolus or two boluses overnight, but I remember another patient I've had with in obvious obvious pain, getting like four or five boluses an hour so and you know and increasing the rate or something <i>(Yeah)</i> just to get rid of, you know, four, three to four an hour, it was a lady who had oesophagus, you know, <i>(Yeah)</i> that would be very painful, suctioning that, I mean I was giving four boluses <i>(Yeah)</i> an hour to her, <i>(Mm)</i> and still having an infusion going, and nothing you know, I was thinking, you know, I'd think "Oh, god have I given her too many boluses for that hour? Will it all accumulate, and <i>(Yeah)</i> bomb her out all at once?" I'd think like that too, but I'd think, "Oh well no, 'cause she's still <i>(She's still awake)</i> obvious <i>(Yeah)</i> and in obvious pain." <i>(Yeah)</i> Actually I liked when I'd give it to her and it would zonk her for a minute like <i>(Yeah)</i> so she wouldn't.. and j" and I and I remember she was tubed but she was with it enough to, I'd say, "Would you like me to make you drowsy or to put you a bit to sleep for the next twenty minute, half an hour", and she'd nod <i>(Mm)</i> you know, so I'd give her a bolus and give her an extra bolus and leave her, make her comfortable while I turned her or, <i>(Mm)</i> and I did that ten minutes before I knew she was, you know, especially suctioning her 'cause <i>(Mm)</i> you know, she had ICC's in and she was in pain like <i>(Yeah)</i> and nothing could control like <i>(No)</i> so I thought the best thing was to make her comfortable and she preferred to be asleep for the hour while you did stuff, or half hour. <i>(Yeah, yeah)</i> So if they're, well if they're they're with it enough to say, "Yeah, I'd like to to go go to sleep <i>(Mm, yeah)</i> for this period." Like I'd just have no no qualms <i>(Yeah)</i> about putting them to, you know, if the order's there and .. <i>(Yeah)</i> (9:21,2-36)</p>
addiction	<p>Patrick or looking into things like, um, are we getting people a little bit addicted as well <i>(Mm)</i> whilst they're in hospital? (5:17,1-3) Toni you know, whether a lot of nurses, especially even when you work in the general wards, if somebody's really wanting their pain relief every three hours you just think, "Obviously, they're getting addicted to it." 'Cause, you know, you hear people say it <i>(Yeah)</i> at handover, "Mrs. Whatsee who had her, you know, appendectomy has been wanting her pethidine every three hours. We think she's getting addicted." Well, you know, that might not be the case, she might</p>

just be in lots of pain that's just her. *(Yeah)* But I think people sort of, ah y'you do hear it, 'cause a lot of nurses say, "Oh, well, you know, we'd better not give it to her because we think she's getting addicted." You know those sorts of things, which I mean, I think we, *(Mm)* you know, *(it's a judgment.. value judgement sort of thing)* It's, it is very, *(Mm)* but you hear it said all the time, you know, that she's she likes the pain relief and, you know, so keep an eye on her. *(laugh)* I mean, she might just be in lots of pain, *(Yeah)* you know, how do we know? *(Has that happened to you that you looked after somebody who had a minor procedure that was in lots of pain, kind of thing?)* Yeah, I once looked after a lady who had, um, just something really minor, just had a K-wire put in her toe or *(Yeah)* something not very flash, and some small orthopaedic thing or something in an orthopaedic ward, and she was, well, appeared to be in so much pain, I thought something else had gone wrong, you know, like, I thought, I didn't know what they'd done, and we got her reviewed and all this, and she was just in pain. *(Yeah)* She'd had, must have had a really low pain tolerance, I think. *(Yeah)* So we got her pain sorted out and she had some morphine and then I think we got her a PCA or something, it went that far, *(Mm)* but, um, it was just.. we couldn't like.. we just all thought, "Oh, she's just you know, *(Yeah)* must be, you know, carrying on a bit." Mm. But she was a bit of an.. not an undesirable person but like she'd been in and out of hospital a fair bit, she'd, you know, and they were querying whether she had like a previous drug addiction and those sorts of things, so we all sort of were trying not to give her pain relief. You know, people sort of thought, "Oh well, you know, she'll get addicted to it." But she was in pain obviously, *(Yeah)* she wasn't just sort of, you know, bunging it on. *(Yeah)* But it was just like, not just a K-wire, something very simple, you know, you just.. we, nobody believed her until we got her reviewed and *(laugh)* you know, *(finally got her fixed)* the orthopod said, "Well, she could actually be in lots of pain, you know" *(laugh)* Yeah, *(And you actually treated her and she stopped, (Laugh))* and she stopped and she was fine - a very pleasant lady, you know (6:22,32-24,6)

Rhea Well, there was a point where they sort of would've were where they tried to wake um, withdraw morphine and midaz and stuff like that because of long term use *(to wake him up)* no, because of long term use and withdrawals *(Ah ha)* Ah, you know when they've been on it maybe two or three months and they do get like um, the tremor and stuff. And they say that, they put that down to withdrawal, *(Oh really)* not, I know they say that it takes a lo'lot longer than that to become addicted *(addicted yeah)* to um, morphine and I know morphine in particular. *(Yeah)* But I'm sure pethidine's exactly the same, *(Yeah)* um, but that's what they were putting it down to, *(Oh right)* and they have done that with different patients in iso. If you've been on long term midazolam, or may be its because it's a combination of midazolam *(Yeah)* and morphine and its more the withdrawal from the midazolam, um, but that's what

	<p>they put it down to and they do try and stop it completely (<i>Ah</i>) and I know that's what they were doing with um, P. (<i>Oh yeah</i>) A couple of weeks back (<i>Yeah</i>) um, and he, and his tremor, although he had it pre op, but we didn't see um, his friends and family said he did have a bit of tremor, but his was really noticeable and they were putting it down (<i>Oh right</i>) to withdrawal. (<i>Mm</i>) But it would have to be a combination of morphine and midaz. (8:11,8-31) it's not that they were not trying to give it, like they sort of come to the conclusion that its time to stop. (<i>Oh, I see</i>) Its not, "Don't ever give it because of.." you know (<i>Oh right</i>) its just they get to this point, you know its time we should consider stopping. I think (<i>Because they have the tremor and then they stop. Do they have the tremor after they stop?</i>) Um, no, they've tried to wean or tried to wake them (<i>Oh right</i>) slowly (<i>Right</i>) and I've noticed that its, I mean, they put this ah, sort of this a bit of agitation down to, have you not, I suppose you don't see it at night (<i>No, you see, most people really um</i>) no, I can't sort of (<i>are more sedated at night</i>) Yeah, Yeah, and I can't sw.. you know swear that this is gospel (<i>Yeah, oh it doesn't matter, I'm just interested..</i>) I know with P and P (<i>Mm</i>) that's sort of the way it went, (<i>Yeah</i>) it was, you know, we've got to consider stopping this or we, you know reducing it to stop it. I think with P they reduced it and stopped it. I think, I'm not a hundred percent sure they did that with P but they possibly could have. (<i>Mm</i>) I mean, I'm not there all the time. (<i>Yeah</i>) But they get to that sort of, to you know, think about six weeks, and you sort of look and, "Oh god, they've been on this for a long long time" (<i>yeah</i>) and consider reducing it and, maybe I'm not there but I'm fairly conf.. you know discussion about it (8:12,1-25) can you justify continually giving someone a a narcotic (<i>Yeah</i>) on long term basis because he should have pain? (<i>there might be</i>) or because they might, that, yeah. (<i>Yeah, its really hard isn't it /like..</i>) Well, I don't know, well I mean, I, yeah, it's a fine line isn't it? (8:13,16-21)</p>
<p>(b) liberal (ICU is safe)</p>	<p>Petra most people probably need some sort of underlying or um baseline type of pain relief (<i>Mm</i>) to a degree, depends on their level of um tolerance of pain as well, but that's quite hard to assess in our situation. (10:3,8-11) Patrick says we tend to give them a little bit, probably a little bit too much pain relief, just to make sure they're getting enough, rather than, um um, being on the other side, and I think that's quite, I think that's quite a good thing, because at the time it doesn't really matter to them whether they're too, you know, (<i>Mm</i>) drowsy, or it doesn't sort of influence their sort of, um, recovery at that point in time. (<i>Mm</i>) So I think that, um, although we sort of try to, um, we have our pain chart and we sort of try and titrate our pain control to level two, but I think a lot of the time its sort of at around level one and and and, um, yes, so I think that that's quite good (5:2,10-21) I think often it is even like the level 2 is a guess. (<i>Mm</i>), And I think because it is a guess, as I was saying earlier, I think we sort of try to be a bit more on the (<i>Mm</i>) over side rather than on the</p>

	<p>under side. (Mm) Nothing wrong with that at that point. (5:16,3-7) and Toni adds its probably not going to hurt them one way or another, so you're probably better off to give it rather than not give it. (6:14,2-4) Bryce thinks I think some people are sort of laze about it and they they go, "What the hell, he'll be right, he's ventilated, he'll be fine." Um, which which I guess, when you think about it, is good and is bad, I mean, ah, I mean, people think yeah, "Respiratory depression, OK that's the primary (Mm) sort of side effect." (4:14,17-22) Leticia recognizes ICU as a safe place for this type of patient give them a bolus of this and a bolus of that and seeing that it was okay to give and recognising that they are fully ventilated anyway and this, they may stop breathing but its not going to compromise their their lives (1:7,1-5) try it and if it doesn't work then you get something else, but if it does then you have the autonomy to do that and you can do that quite safely. (1:7,27-29) Asha also is aware of the safeness of ICU realise that the patient was very safe, they weren't going to die necessarily because I turned them and, you know, forgot to do something or something like that (2:5,30-32) and today she notices some less experienced nurses I noticed this, I think with the younger nurses in ICU particularly because I think they're scared, they're new th'they're so worried about the ventilator, the monitor, the machines alarming, and you see them turning a patient, or when they're trying to sit them out or something like that, and you just think, "Oh, that catheter's pulling", you know, or "Watch her head" or, you know, "You've got the tube across here, its gonna be, no wonder they're gagging on the ventilators" so, um, yeah I'm always really aware of the patient's comfort more that the machines alarming, I mean, I I always think ICU, an ICU patient is the safest patient you can have, especially if they're tubed, they've got a tube down their throat, they're not going to stop breathing, you know, if they do, its very easy to look after, anything that happens to them you're going to pick up early, you know, I think you're safer than a ward situation some of the time, because you've always got a doctor there, you've got skilled nursing staff at some stage, so I think we can afford to be a bit more careful of that rather than worry about machines alarming, and I think we forget (2:1,27-2,9) Rhea its happening more on a routine that they are actually putting up morphine and midazolam up as an infusion, in these type of patients regardless (8:16,4-6)</p>
<p>it's a new admissions</p>	<p>To settle them in Robyne sees analgesia and sedation as a way of making a new patient settle into ICU morphine, midazolam, is always, someone's always had it at some point in their admission and its always sort of the first, I think, you know, twenty minutes that a.. that that's dealt with. Whether that's to, you know, just to settle them in a little bit. (3:9,17-21) for post op admission give analgesia to ventilate and treat BP and prevent complications</p>

	<p>Robyne I mean its always the first thing when you come back, they come back from theatre, partially because you don't want them waking up really quickly and going berserk, and their blood pressure getting out of control, (<i>Mm</i>) and s'all of that type of thing. You know, yeah, quite often it's just because they are in pain that all those things are happening, (<i>Mm</i>) so you just try and resolve that and get that step out of the way and then see if maybe the blood pressure is due to something else (3:5,17-25) Patrick I think it was DL brought back, um, a patient from theatres and you know, blood pressure sky high and and you sort of immediately go "Oh sublingual adalat or SNP infusion," and then they sort of, "Ah ah, just sort of give them some morphine and some midazolam and (<i>Yeah</i>) that'll be fine." And you just go, "Okay, I'll do that," Oh, it really works. (5:8,29-34) Toni you know, if they haven't got adequate pain relief, it can sort of impede their recovery, 'cause then, they're less likely to breathe up for you and not able to extubate them and those sorts of things, 'cause they're in pain they won't, you know, breathe up, so you can sort of.. or they won't walk and do their deep breathing and those sort of things.(6:2,10-16) Beth so often when they come back from theatre and they're not responding (<i>Mm</i>) but they're very hypertensive I find that a lot of the anaesthetic registrars will immediately say, "Morph, Midazalam and" (<i>First</i>) and (<i>Yeah</i>) its yeah, just a way of settling them down too (<i>Yeah</i>) and they're obviously, you know, the patient's obviously in pain although they haven't been reversed and (<i>Yeah</i>) and (<i>Yeah and that's good, yeah</i>) mm, sort of thing, and sometimes I'm even tempted to even have it there ready because you you know what's going to happen (7:7,19-29) its very obvious when they come back from theatre its often, you know, the way of settling them down if they give them quite a large dose of (<i>Mm</i>) large sort of increments of morphine (<i>Mm</i>) and midaz. (7:8,1-4) Especially the post op cases, (<i>Mm</i>) yeah because they don't anticipate that, as I said, often I'm almost tempted to have (<i>Yeah</i>) the drugs there ready (<i>Yeah, 'cause you've seen enough.</i>) Yeah (<i>Yeah</i>). And they may be just more concerned with just setting up the bedside, getting them hooked up (<i>Yeah</i>) and that, whereas its hopeless trying even to ventilate them sometimes because.. (<i>Yeah, that's right, yeah</i>). So it's better to get that the analgesia part sorted out first. (<i>Mm,</i>) Um, and then, there's you know the danger of hypertension depending on what sort of patient it is (<i>Mm</i>) unless you sort it out quickly, (<i>Mm</i>) they can rebleed, carotids blowing (7:8,22-9,1) Rhea when the patients first come back from theatre sometimes you have to prompt (<i>Mm, yeah</i>) " Oh, could we have one of those or why don't, or there any reason why like five hours down the track they don't have one," and its "Oh, oh yes, sure, that's OK" You go, "Oh right" um. But then I suppose its our responsibility too to consider (<i>Yeah</i>) these things. Um, no, I think they're pretty good. (<i>Yeah</i>) I can't say that anybody was particularly good, um, except in those that you prompt and say "Oh, you know, have you forgotten" and they</p>
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	go “Oh, OK” you know “put it up” and you think, yeah, you feel much happier about it (8:16,7-18)
(d) Body size of patient	<p>Letitica I would've thought, well, he's a bigger man he'll need more pain relief (1:13,31-32) Petra , I usually start with the baseline of what you'd think for their weight (<i>Mm hm</i>) um, and probably add a little bit more to that anyway, and then, um, if they're reacting to, if they're having changes in their blood pressure and their pulse when you're touching them or moving them or anything then you give them a bit more.(10:2,9-15) Bryce remembers his time in oncology you're providing, I mean, regular fourth fourth-hourly where.. I mean, I.. sort of, um, yeah. Whether whether it was oral.. um, just sort of, just just throwing morphine like you wouldn't believe, I mean, um, orally say, something like, um, up to sort of 200 mgs, (<i>Mm</i>) morphine, um, which is sort of.. (<i>laugh</i>) you're thinking, I mean, that's a lot (<i>laugh</i>) a lot of morphine to be to be giving someone, (<i>yeah</i>) and then going from there and finding this person still up and walking around and asking for more and y'you giving them another 5 mgs subcutaneously. (<i>Mm</i>) Um, whereas you you can find.. and they might be the the frailest of of young ladies or something like that that you think, “How's this person tolerating that?” (4:10,16-27) In ICU Bryce continues to consider body size I mean if a if a protocol says to to start at say for argument's sake on five, I mean are you going to start that on a on a thirty kilo lady, I mean that's (<i>Mm</i>) a thirty kilo lady, that's not really, that's (<i>yeah</i>) y'you got to you can't say the protocol said to start it at five. (<i>laugh</i>) No you've got to, you have to (<i>yeah</i>) consider that maybe that's going to be way too much (<i>Mm</i>) start it at three or four or something just to see how we go, um, so mm the opposite way around, y'you've got a hundred and twenty kilo strapping guy sitting there, and you're expected to start it at two, that's.. no its its not on, (4:18,8-18) Rhea if it's a big person we start off at a higher rate than we than we would for somebody smaller and that has been going on for a long time, somebody's bound to have hit it right somewhere along the way (8:7,16-20)</p>
(e) what the nurse can see	<p>Bryce they can still in a sense show that, “Yes now this is comfortable that's great.” and then I think you've reached a a state that's good keep it at that. (<i>Mm</i>) But, um, if you've reached the stage where you can totally manipulate them, and um, you could make them into a into a contortionist and they don't mind then, um, you've gone too far. (<i>Laugh</i>) That's a bit of an exaggeration (4:7,7-13) Robyne uses a rule of thumb when I'm working with someone who's paralysed, I I the they're on about at least, if they're a head injury patient, they're on at least about 3, 3 or 4 mls of morphine an hour via an infusion, that's like, if it was 2, I'd be thinking, “Oh, maybe that's not enough, you know, oh, (<i>Mm</i>) don't know about that.” Um, if its a, you know, multiple fractures and stuff like that, I'd be more edging toward the five. (<i>Mm</i>) And those times when they are lighter and they're not paralysed, um, and</p>

	<p>you're doing things with them you can see <i>(Mm)</i> sort of where you're at, <i>(Mm)</i> you know, a little bit. (3:8, 12-22) Rhea I know that that tube in your mouth <i>(Ah)</i> could be so uncomfortable <i>(Yeah)</i> I mean, its necessary to have something <i>(Yeah)</i> to compensate for that as well <i>(Yeah)</i> um and that's, I mean, for them to look comfortable (8:6,31-35)</p> <p>Bryce remembers patients he has looked after in similar situations to give him a baseline for administering analgesia, then he titrates the dose to any indications from this patient Because I've, I mean, I've seen situations where you can give.. think, "Oh, my god, I've given this person way too much but turned around in ten minutes and find that you've actually got to top them up again, <i>(Mm)</i> because no matter how much of the narcotic you've given them, they've tolerated that, and um, it hasn't been enough, so y'you look at situations and ah, and its its its a sort of titration, so ah. Yeah, you look at you.. how you other people have reacted, "OK this person's got similar injuries whether it be from an operation or whether it be from a <i>(Mm)</i> sustained accident and so, right OK, the last guy that I gave this amount to he went overboard, maybe I'll just cut that back and go from say half that, and that fits if he's feeling good, then I can give him an a little bit just every now and then to keep him <i>(Mm)</i> over that." So.. <i>(So you've sort of got a certain base and then you titrate it from there.)</i> Yeah. <i>(Yeah)</i> Yeah um, so, yeah, y'you sort of get them to a peak I think, and if you think that peak is verging over the top, then you slacken off a bit and wait till you've sort of come back down a little bit and then start to keep them at the top again <i>(Mm)</i> or y'you keep pushing that little bit more to try and get to the desired effect. (4:9,20-10,3) Patrick also thinks of what he does for awake patients So maybe what we should do instead of like having a constant infusion, maybe we should cut the infusion <i>(Give them a bolus.)</i> yeah, and then give them a bolus 5 minutes beforehand <i>(Yeah)</i> or something <i>(Mm)</i> and that would sort of.. <i>(cough)</i> because I know we do that with people who are more, um, with it anyway, <i>(Mm)</i> you know like the triple A's and stuff, <i>(Yeah)</i> when you turn them. (5:5,9-15) Patrick I guess you always try and you sort of, when its available, sort of, give them a bit of morph before you do dressings like that. <i>(Mm)</i> But then we don't sort of do that for turns and stuff like that. (5:15,22-25)</p>
<p>(f) advocate for analgesia</p>	<p>Asha says I remember us nurses standing around the bed and arguing with the medical staff saying, "They must be in pain.", you know. And they were saying, "No, look at them." And we must.. obviously we didn't have pain relief up, but I remember they'd just had like a triple A or something like that and they them saying, "No, we don't want to give them anything." And us saying, you have to give them 24 hours at least or something like that (2:14,10-17) Asha asserts her viewpoint when the doctors withdraw analgesia when we've had patients and they want to wake them up and they've just had major abdominal surgery and they say, "Stop everything.", and</p>

	<p>you go, “Hang on, you know, if they were on the ward they’d be getting four-hourly morphine or pethidine.” <i>(Yeah)</i> As you say, its just that they can’t tell you, but no, they want them to wake up to get the tube out. Well surely there’s a fine line where you can still.. obviously, there must be because we give people morphine who are conscious <i>(Yeah)</i> and breathing <i>(Yeah)</i> but yeah, we forget. (2:12,34-13,6) Beth is more politically correct Its, you know, what the doctors say <i>(Yeah)</i> You have to go along with it otherwise “you’re rocking the boat” <i>(Yeah, yeah)</i> and upsetting everybody. But, there again, if they’re absolutely , well, I’m forgetting that they can’t indicate so <i>(Ha)</i> Yeah, no, we might have to forget it, although if you felt that they were in a lot of pain you’d could like try and get somebody to review the order. <i>(Yeah)</i> and assess the patient, but.. (7:7,4-11)</p>
<p>outcome: pain is dealt with</p>	<p>Toni you can only do so much if you’ve got really strict orders as too how much <i>(Yeah)</i> you can give (6:7,16-18) Bryce OK, we’ve quelled the physical pain, but we want we want this person to feel comfortable as well <i>(Mm)</i> cause there’s that thing, I I could, you could, if I was in physical pain, you could put me in a position where I was uncomfortable too. <i>(Mm, yeah)</i> So um, you got to try and get that person (laugh) its like a big fork isn’t it, a two pronged fork, you’ve got to try and ah, <i>(yeah)</i> pick both things in one hit. (4:11,19-26) Rhea if you get to a point where you’re maintaining an acceptable sort of blood pressure and heart rate and the patient is, you know, looks physically calmer from agitation (8:6,26-29)</p>
<p>(but) outcome: nausea - relieving pain causes discomfort</p>	<p>Bryce is aware of the possibility of nausea but there’s nausea as well, I mean, there’s this person sitting there and can’t move and literally trying to wrretch their guts up ‘cause they’ve had it.. I mean, we we don’t <i>(Mm, we don’t think)</i> I mean, when you think about it we give morph and midazolam, how many times on the ward, I mean, if if you’ve.. when you last worked in the wards, or say down in a acute sort of a a ah, like um, <i>cas</i> or somewhere, how many times have you given someone just 5 mgs of IV morph to quell a bit of pain, and they’ve gone, “I feel sick now,” and thrown their guts up. But we don’t give any maxalon or anything like that (...) regularly <i>(large aspirates and you wonder why they’ve got large aspirates (laugh))</i>. I I know, I mean, <i>(yeah)</i> perhaps, um, it would help to.. OK there’s side effects again from each of those drugs, like maxalon, <i>(Mm)</i> but um, but it it may.. that could be one thing that is enough to help that person through, <i>(Mm)</i> because, OK its provided the pain relief, OK m’my broken leg’s feeling quite good now, but shit I’m feeling pretty crook , I mean, <i>(Its like that two prong pronged fork that you said before)</i> yeah it is definitely <i>(you’ve caused discomfort)</i> yeah its um its a catch twenty-two <i>(Mm)</i> y’you’ve corrected one but you’ve caused.. perhaps um, I mean, y’you.. is there any contra indication as to why we can’t put, um, I mean say, what we’ve got 100mgs in a hundred of morphine, why we can’t say put 20 mgs. maxalon in there to try and..? (4:14,22-15,9) why can’t we say give</p>

	<p>it even six hourly, <i>(Mm)</i> sixth to eighth hourly, sort of, just a TDS dose, <i>(yeah)</i> um, help them through because, I mean, OK they they might be really feeling quite nauseous underneath all that so, and do.. I mean, ha ha ha that raises a question, “OK, is the person wriggling around because they’re agitated, they’re they’re in pain or are they sick on the stomach?” <i>(yeah)</i> And we go, “Oh, they’re in pain.” and give them another bolus <i>(laugh)</i> just to help them along <i>(laugh)</i> and we put them out, I mean. <i>(laugh)</i> So what have we done? (4:15,20-30)</p>
<p>Attempt (ii): Routine comfort tasks (turning)</p>	<p>Bryce thinks nurses have a lot of control over the patient through routines in comfort care How we want to control, we we think yeah, sure, we’re making them comfortable rolling them from side to side, but does that person really sleep on side to side, they might sleep on their stomach and just solely their back, <i>(Mm)</i> no wonder they get tense when we put them on the left side and their right side. <i>(Yeah)</i> So and um, so the relatives come in and say, “Oh no he hates it on his side, he just can’t stand that. He always sleeps on his back.” (4:3,21-29) Patrick we’ve got our standard positions of of positioning the patient and, um, <i>(laugh)</i> I was talking to someone the other day and there were sort of like, um, went to, sort of went to bed themselves and sort of positioned themselves <i>(laugh)</i> as a patient, the the way we we position our patients, and they sort of said that that wasn’t really all that comfortable. (5:2,24-30) I think one says that the position of the patient.. and I think you can like do, you know, your standard stuff, make sure that their head is, sort of, in a comfortable position, sort of not like screwed with their neck, that their back is nice and aligned so they don’t sort of get too much back pain from those awful mattresses, <i>(laugh)</i> and, um, yeah. Also, um, you know, a pillow between their knees, and the thing is is that.. the difficulty of this is that everybody has that most, sort of, comfortable sleeping positions and you just can’t communicate that with them at that time, so you just sort of assume that, you know, by sort of switching them over every couple of hours, at one point you’ll have them in a comfortable position for at least two hours (5:3,3-15) I think sort of you’re limited to, um, um, our sort of really narrow sort of boundaries, as in patient left right on their side, you know, and bla bla bla this, and there’s a handful of things we do and then, I think out of.. sometimes out of I think, time as I was saying, but also the fact that we also get locked in to this automatic pilot often and I think it sort of prevents us from exploring other things (5:9,11-18) Rhea I don’t like the word ‘routine’ because I mean I know you do individualise it but <i>(Yeah)</i> the more experienced you are, you don’t think about it before you do it any more and you doing it because <i>(It’s like driving a car)</i> this’ll make it.. yes, this’ll make them more comfortable this’ll do it, this’ll do it, you know. <i>(Yeah, yeah)</i> And you do, you modify it for each individual patient but its not something that you analyse as you go to do it any more, <i>(Yeah, yeah)</i> but there are, as I said, there are, you know you don’t</p>

	<p>think of the cannulas and stuff, things that it is worth (<i>Mm</i>) bringing up and discussing again (<i>Mm, yeah</i>) (8:30,6-17) Rhea there's a lot of things that we don't, at this point don't consciously think about, but we do as a matter, I don't like to use the word 'routine' but we, because you're experienced you do do the li'..., you do some little things (<i>Mm</i>) that you do because you'd been through these stages of talking about it and discussing it and thinking about it and you do it as a matter of routine and part of (<i>Mm</i>) what you do to make someone comfortable. (8:29,19-27) like positioning, you know, you'll think (<i>Oh yes</i>) you know that little extra you know, you'll pull that pillow round a wee bit more just to support under the neck. And um, um, the mouth care, you know, I mean I know a lot of new people will sort of think um, I know you do it, but you know when you've been there longer, you just do them, you don't think about making them comfortable, this is something that you do (<i>Yeah</i>) unconsciously you're doing that because you know that you're making them comfortable (<i>Yeah</i>) but we don't actually sit and analyse it any more (<i>Yeah</i>) because (<i>Yeah, its just part of how you nurse them</i>) <i>Yeah (Yeah) Yeah</i> and I don't like the word 'routine' because I mean I know you do individualise it but (<i>Yeah</i>) the more experienced you are, you don't think about it before you do it any more and you doing it because (<i>Its like driving a car</i>) this'll make it.. yes, this'll make them more comfortable this'll do it, this'll do it, you know. (<i>Yeah, yeah</i>) And you do, you modify it for each individual patient but its not something that you analyse as you go to do it any more, (<i>Yeah, yeah</i>) but there are, as I said, there are, you know you don't think of the cannulas and stuff, things that it is worth (<i>Mm</i>) bringing up and discussing again (8:29,32-30,17)</p>
<p>Outcome of routine care: Minimising</p>	<p>After working in the unit for a while, it is easy to see routine things as not consequential. Rhea I think its important that we realise comfort (<i>Mm</i>) as well as what you perceive as pain. (<i>Mm</i>) Physical pain, surgical or whatever, um, discomfort is going to be just as bad and its going to nag just as much as like a physical pain inside, you know or whatever (<i>Mm</i>) and we've got to remember that, you know, the tubes just can be as annoying, (<i>Yeah</i>) it won't be because of physical pain but because they're there annoying all the time. (<i>Yeah</i>) Its going to be just as bad as pain (<i>Yeah</i>) and that would be justification for giving them something for comfort (<i>Yeah, yeah, I agree with that</i>) 'Cause that can be forgotten about I mean and I think people new to the unit don't think about it at all (8:26,30-27,5) I had a drip in my, in my hand it was the most painful thing I ever had and everybody the drip was out like this and everybody kept knocking it and it was agony, (<i>Mm</i>) absolute agony, (<i>Mm</i>) my hand was black for days and that was and too another thing that I always remember was um, I asked the nurse for, I hadn't had any analgesics the first night and I asked her for a, like I was fourteen, I asked her for can I have something to help me sleep 'cause I didn't sleep the night before, first night post-op. And she said, "Sure" and she came back and drew back</p>

the curtain drew back the covers and jabbed this needle in my leg and I was convinced she was going to give me a couple of sleeping tablets, fourteen very naive um and she jabbed this.. and you know that was more painful than my abdominal s' (*Oh really*) abdominal wound, it was agony, and I had to walk and everything and that was just an injection, so we don't think about that at all. (*No*) And we're, you look how much heparin that we give (*Yeah*) and they're black and blue and we don't even consider it (*No*) it just doesn't come into it, you know I suppose we do have to prioritise but those small things can make a difference too. (*Yeah, yeah its amazing*) I, you don't, you don't even consider it (*and its not until someone actually brings it up from that sort of low priority that you like, and even then you might forget it after a little time.*) Oh yeah, yeah. Well, I mean, until you, well you're not looking at their abdomen all the time so you like don't see all these little purple scars until, or bruises until you give the next injection. You go, "Oh that must be awful sore" and then you know you their ICP shoots up and then you go, "Oh, oh gosh" you know (*Yeah*) and its not a priority any more (8:27,12-28,5) we were at a respiratory um, conference actually a couple of months back with the unit and um, the guy there said he spoke to a patient who said it was like the living air had been sucked out of him and every, you know when you cough and you have something caught in your throat and you cough and cough and you just have to try and catch your breath (*Yeah*) but you knew it was going to happen he was describing it as a fact that you'd sucked every last drop out of him (*Ohh*) and he just felt that he was never going to get a breath because the suction catheter had taken up everything (*Ohhh*) um, you know, and so if you think you're doing that every hour or more frequently (*Yeah*) on the patient, I mean, they must be just exhausted (*Ohhh*) you know, the mental anguish you go through (*Yeah*) at the same time and you think that with this and you can't catch your breath, you know, it would be horrible. (*Yeah*) 'Cause I mean your your basic, your basic instincts are that you breathe, breathe, breathe and you just can't do it it must be horrible. (*Yeah*) But yeah, no I have remembered that. But how do you suction more gently, I mean, there is a point where you just don't ram the catheter down and back up again but.. (*Yeah, yeah, but I mean apart from that ..*) the quicker you can actually do it, its probably the more sensitive thing to do. (8:28,18-29,4) **Leticia** And of all the things that you do, like suctioning, sort of the easiest (*Yeah*) and you just go and do it, (*Yeah*) you know that that causes them distress and yet that's always when they want to get the tube out and (*Yeah*) and move around and, like you can do most other things to someone (*Mm*) and they tolerate it but suctioning is something that's (*horrible*) is just horrible, and you just go, "Oh, a bit of a cough coming up now.", and ram this tube down their other tube (1:10,11-18) **Bryce** I think there's more discomfort than pain associated with with that than um with a lot of people (*Mm*) that we realise (*Mm*) um. I guess the majority of staff haven't had a tube

	<p>something put down their throat that's ah (Mm) (laugh) (laugh) a half inch in diameter (laugh) to see what it feels like, so um, yeah, can we really sort of like say, "It's all right, you relax." (4:5,22-28) Patrick I guess you try not to, but I think that if your patient, is sort of, you know, your patient is conscious and the eyes are open I think you tend to turn, I think you tend to turn a little bit more, um, (cough, excuse me) tend to, I don't know, to try and be be just that degree more gentle, (Mm) because you can actually sort of, you know, the visualise that, you can sort of see the pain, (Mm) whereas, I guess, with the with the very unconscious, you sort of, um, think 'cause they don't, sort of, aren't able to show their pain to.. I don't know. Sometimes I sort of notice that with, sort of, when you get help with turns and stuff on on nights. Mm (Yeah, you can see it too and) Mm (do something about it) Mm, sort of, um, (Mm) sort of, the old Heave ho! (5:6,8-20) Toni even doing a blood gas. (Yeah) I got.. one of my friends did a blood gas on me last year, (Oh) 'cause I wanted to see wh'what it felt like, 'cause, you know, I always used to say, "I'm just going to do a little prick, it'll hurt a little bit." (Hurt a bit) 'Cause we used to do them all the time. (turn tape over) ..bored, and I thought, "Oh." I just wanted to check, wanted to check my haemoglobin just on a gas, so I thought, "Oh well," so I said, "Just do a blood gas." Oh, it was just excruciating, (Really) OK, it was terrible, it really, really hurt. I had pain radiating all the way up my arm. (Oh) I'd I 'cause, you know, how you always say, "Oh, it'll hurt a little bit." Ohh it was absolutely dreadful, it was worse than having a blood test or a cannula put in, really hurt and then it throbbed afterwards. (Ohh) And it wasn't as if she did a bodge job, 'cause she got it straight away, (Yeah) yeah, and after that I've always been, (Laugh) "This will hurt". (Laugh) You know, I think you better.. ("This is really going to hurt"). I think you're better to be honest. That's the same as when you're working with kids, you know, like, if you're going to give a kid an injection or something, you're, you're better off to say, "This this will hurt a little bit." rather than say, "Oh, just a little.." you know, "Don't worry, this won't hurt." 'cause you shouldn't, 'cause its going to hurt, (Yeah) and then otherwise they sort of get this thing that, you know, "Well, that nurse told me that it wouldn't hurt and it did and.." You know, kids are very.. you've got to be very careful with kids (6:24,14-25,5)</p>
<p>(but) Outcome: complication of trachea nearly dislodging</p>	<p>Asha remembers an incident I remember turning someone and the wardspeople were in a hurry, it wasn't, it was like the wardspeople came up from the wards, the orderlies, and, um, they were in a hurry, so we turned my patient and my trachy tube nearly came out, (Mm) 'cause I was in a hurry and I wasn't, I didn't communicate with the patient, and the patient was trying to tell me that something was wrong, and I didn't listen to the patient, I was too worried about getting this patient just turned, again that's just, its a task thing. (Yeah) I had to turn the patient and that was that. (Mm) Um, I can't</p>

Appendix W
Collective story in four episodes – *creating four episodes*

	<p>think of specific things but I know that its happened to me where patients have tried to communicate something to me and I haven't listened to them <i>(Mm)</i> and they've been right, and god you feel bad afterwards. <i>(Hm)</i> Yeah. And um, i't must have happened to me, but, you know, I see it now when people are trying to.. and I think we get harassed by other people too, <i>(Mm)</i> we all do and we do it to people I'm sure, everybody does it, you know when they're trying to turn someone and the patient's just coughing and gagging, sputum's pouring up the tube and, you know, you often say, "Let's stop, suction the patient and we'll go on then." and, you know, the the wardy or whatever says, "No, come on, come on, I've just got to do this." or x-ray says, "Look, <i>(Mm)</i> can we just take this x-ray?" <i>(Mm)</i> and , you know, it takes a bit, I guess its age as well, you know, a bit of maturity and, um, confidence to say, "No, I'm going to suction the patient." and, you know, there's times where you've had to do, where I've had to do that and that's the big thing that we're patient advocates. (2:6,2-29)</p>
<p>Routine care (positioning)</p>	<p>Rhea Well routinely, you know, while we're positioning the patient <i>(Yeah)</i> in the position that we, well obviously we look at, and well, does it look comfortable to start? <i>(Yeah)</i> Or in alignment? Which is the normal position for limbs and things like that and we're always pretty good about supporting with pillows and using extra blankets and things like that. <i>(Mm)</i> Um, (4 sec pause) checking to see that they're not lying on parts of the equipment and stuff . You sort of picture yourself in that position you know, if you were lying <i>(Yeah)</i> in the bed in a position that looked uncomfortable, you know, would you lie like that when you're trying to sleep? <i>(Yeah)</i> You've got to sort of look at it that way, well that's what I think, <i>(Yeah)</i> um, and that they're not lying on anything on the wrinkles in the bed, 'cause, you know, I wouldn't which I'm paranoid about. <i>(Laugh)</i> I think, when you turn them over and you see this huge big crease on their on their skin, I mean, it must be so painful and I sort of think of that, you know, the nursery story the Princess and the Pea. <i>(Oh, yeah, yeah)</i> You know, I mean, that's the same thing, I mean I know, <i>(Mm)</i> my bed's one of my precious places and like it has to be very comfortable <i>(Yeah)</i> and it has to be the same for them. Um, otherwise, the position would have to be the most important because they can't tell me and that's something we can see and do something about. (8:2,1-25)</p>
<p>Attempt (iii): mattresses/ pillows</p>	<p>Patrick from reports of people being on those mattresses for any length of time, they're sort of not the most comfortable, which.. I don't know, I guess we're trying to get better.. um, but I guess those spanco mattresses, um, although they're good for the skin, I'm not quite sure whether they're too good for the back, because, I mean, they sag <i>(Yeah)</i> and sort of, you know, sort of fold up underneath you and <i>(Yeah)</i> have lumps here and there and.. <i>(Yeah, but there's those new blue ones,)</i> <i>(Mm. (they should be a bit better.))</i> Yeah, I haven't heard, we sort of had a, um, I guess its difficult to.. not difficult, I shouldn't.. its not difficult, its sort of.. if the patients could sort of tell us, um,</p>

	<p>which one's more comfortable, I guess they'd need to be on both, <i>(Mm)</i> but they're on either one, o'on one or the other. I think there was there was only one occasion where we, um, where we swapped a guy from one mattress to the other and had a direct comparison and he felt they were a little bit more comfortable. <i>(Mm)</i> Certainly nothing like the medicos bed that they <i>(ha)</i> ah, you know that one with the different cells, <i>(Yeah)</i> that sort of blows up <i>(Yeah)</i> I think that that was the.. I think that was the one voted most comfortable, in in N S Hospital, I think. (5:3,30-4,14) Patrick you know, you fluff up the pillows (5:24,9)</p>
<p>Attempt(iv): Basic hygiene</p>	<p>Robyne would prefer to cure pain rather than take more time consuming measures I always find those Guillain Barres very difficult, <i>(Mm)</i>'cause their, the type of discomfort they're experiencing is not necessarily cured by what we've traditionally given people to cure pain, <i>(Mm)</i> to ah help pain, you know, they want to be cool and washed and, yeah. Its very demanding the type of things that they require, ah in, to, you know, help their pain, so, I mean that was, that's difficult. (3:9,6-12) Patrick I think there's also stuff like, um um, having, um, a clean, say a clean mouth, and having their mouth cleaned very often. I think that's a very sort of big part of of being comfortable <i>(Mm)</i>. Having that awful taste out of your mouth, whether they could sort of realise that at the time or not, <i>(Mm)</i> you know, this sort of patient you wouldn't know, but it sort of becomes an issue later on. Um, general sort of like the eyes, you know, not sort of clagged up all the time, I think that's a big part of comfort. <i>(Mm)</i> And also, um, like just wiping someone's, um, forehead or head just with a, with a sort of like a warm damp cloth every so often I think that's, does a, does a lot for them. (5:3,16-27) I guess that's another comfort issue is is, um, is to wash in the morning and and I think that, I think especially, um, y'um, I think that's probably very difficult to sort of um, sort of visualise for like say, female nurses, but like a shave in the morning, is just like, its beautiful, you know. You'd feel like, you feel alive again, and its nothing like getting out of the shower and having a good shave and um, so I'm like, one of the things I that I its like um, there'd be no way I wouldn't shave somebody in the morning, like, I mean, unless you know given its like <i>(Yeah)</i> you know you can't sort of expose them or something because its too cold or something its sort of one of those things is one of my sort of things is a guy's got to have a shave and and I think sometimes its a little bit forgotten as well just little things like shaves. <i>(Yeah)</i> and and yeah, I mean, what you mentioned, hair washing and stuff, I don't think that's done enough either. (5:11,28-12,6) Rhea I know what I've done on numerous occasions is get a basin of water on the bed and put people's feet in it <i>(Oh yeah)</i> because when I was in hospital the the sheets were all tight around my feet and it was driving me nuts when I had the pain and it was this was driving me nuts and I'd said to the nurse,</p>

	<p>“Would you mind, no matter what you do to straighten the sheets around the bottom of my feet” and um, she stood and washed my feet <i>(Mm)</i> and and she literally put the basin on the bed and soaked. And I’ve done it for other surgical patients who are on bed rest and stuff <i>(Yeah)</i> to them its just heaven <i>(Yeah)</i> just your feet - I mean, so I can understand that but <i>(Yeah)</i> I mean and its got nothing to do with their their tummy pain and whatever, but in our particular situation they’re more acute (8:25,10-24) those little extra special things that just make you.. <i>(Yeah)</i> you know, like on another um surgical ward again I know that things like putting the lipstick on and the make-up that makes them a hundred percent better but that ‘s at that point. <i>(Yeah, that would be.. I wouldn’t care, I’d consider that ridiculous at this point.)</i> Oh well it is, it is, but you know, its just a point <i>(Yeah, yeah)</i> but the smallest little thing totally non-nursing related <i>(Yeah)</i> can make such a big difference. <i>(Yeah, yeah,)</i> um, but in our situation I don’t know if its relevant. (8:25,26-36)</p>
<p>Attempt (v): Massage / reflexology</p>	<p>Patrick sometimes you sort of try and give them a bit of a back rub and that sort of thing (5:3,29-30) I guess its easy compared to like being I mean these days, like being at the hairdresser, I mean its more like <i>(Mm)</i> sort of you’re lying back and your head’s sort of .. and give you a nice massage <i>(laugh)</i> very nice. (5:12,13-16) Asha recalls a time that she saw massage work she got a heart lung transplants, her lungs were stuffed, and she got a shocking heart. It it was kept alive on adrenalin so <i>(Mm)</i> she she was never going to live and she was with us for so long, she went into renal failure, liver failure, just everything, total body failure basically, and she never used to sleep. She used to lie wide awake at night and I remember one night, we we had her on massive amounts of diprivan of a night to try to get her to sleep and I remember one night I got some oil or something and was giving her a foot and calf massage and she fell fast asleep. <i>(Mm)</i> And I thought, god, you know, like it took a bit of time I guess and effort but <i>(Yeah, yeah)</i> it was something good to do (2:16,3-14) and he’s the sickest person I’ve seen live. Amazing that he did. He was on like 100% for three weeks. <i>(Oh really)</i> He’s amazing. Um, but his sister used to come in every day and do um, what do you call it when they rub their feet? <i>(Like reflexology)</i> Yeah, reflexology on him, yeah. A friend at work told her that it might work and so she had this little map of a foot that she <i>(laugh)</i> she’d say, “What’s wrong with him today?” and we’d say, “His liver’s off a bit.” and she’d rub his liver section, but she sat for hours rubbing his feet and that’s when he fell asleep. (2:16,15-25) But Rhea disagrees Like doing a bit of massage and um, <i>(Yeah)</i> just a back rub or I’m tempted to say that sometimes its not practical <i>(Yeah, well, I mean, because we’re busy or or)</i> Ah, and they’re also, yeah, and because of maybe certain conditions and position and stuff like that, but also if they can’t tell us, <i>(Yeah)</i> um, and there’s absolutely no way um, what’s the point in rubbing their feet, <i>(Yeah)</i> is that going to solve their headache, you know, or sore ribs,</p>

	<p>their sore tummy we do 'cause they do we don't know where their pain is (Yeah) I mean, we can say, maybe sort of say, "OK, right they've got a head injury, sore head." you know, (Yeah) but um they've got a flail chest, OK, (...) when they're taking deep breaths but you just but (Yeah) you know (What good is to going to do) In what case would you sit and rub their feet (Yeah) I mean, like I can understand and I would spend hours and I know yes, I'd rather sit down too, but like Gillian Barre you know, they can't tell you, (Yeah) and you know that they're sore and they're stiff (Yeah) and the greatest relief to them is if you stood all night and rubbed their hands and feet (Yeah) and just did passive movements with them, and I have done that for them, but I can't.. (Because there's no connection there's nobody that's said, "Because I've had this abdo surgery and it hurts and you've given me morphine and its made it a bit better but if you rub my feet it would be heaps better,") Yeah, yeah (there's nobody that's said that so that you..) or the likes of, I mean I know a lot of people whose beds are damn hard (Mm) and if you rolled them over and rubbed the small of their back I'm sure they'd just be in heaven but is it going is it going to stop the surgical pain that they have or (Yeah) the headache that they have or the.. (Yeah, and is that two minutes worth it?) I mean, I know we do yet is it worth enough, I mean, you know, we put them on their side, and yeah we could stand and rub their, you know, rub their back (Mm) which I mean, we do when we do pressure, (Mm) you know, I like to rub a bit of cream and stuff on but we don't, but we do, its time as well (Yeah) I mean, I could stand there but who, um I don't know if its of benefit. (You need somebody else to help you do that as well and they need to be somewhere else as well) Yeah, but even if you've got them propped on their side (Mm) and you know, give there back a rub (Yeah) or, you know, do, is it going to do any good? Is it going to help their..? See, you don't know. (No, I don't know) So I don't know why um, I would say I wouldn't be, I wouldn't go gung-ho about it, (8:24,2-25,10) I'm sure if you were in one of the Asian countries they would say, look, do a body massage as you're having your bed bath to an unconscious patient, would be you know, so much beneficial to them and relaxing and all the rest, (8:26,1-5)</p>
<p>Attempt (vi): aromatherapy</p>	<p>Rhea I'm all for getting um, scents, you know, essential oils (Oh yeah) and stuff, in in the unit 'cause I think you know, the calming, (Yeah) calm the ones that calm the senses and stuff like that would just be so beneficial (Yeah, 'cause they're so overstimulated ah ha) Yeah, um yeah especially for the sleep deprivation, deprivation down at the other end, but, you know, for the head injured patients I mean you don't know, it hasn't been researched into essential oils as to how much good that they can do in non-nursing (Mm) as well. (Mm) that's one thing that could be looked into but at the same time I learned little things that I don't know if they are appropriate or not (Yeah) but I know what things you need now. (8:26,5-18)</p>

<p>Attempt (vii): Treat minor irritations</p>	<p>Asha suggests you often come along and find people with raging oral thrush or, um, peri fru'thrush and nobody's thought to order nystatin (<i>Mm</i>) pretty easy thing to do, easy to get rid of (<i>Mm</i>) or even excoriation, you know, when people (<i>Mm</i>) have go bad diarrhoea (<i>Yeah</i>) just getting some zinc or doing something just to protect them a bit (2:10,20-26)</p>
<p>Attempt (viii): talk to these patients: (a) prepare patient mentally for procedures</p>	<p>Asha remembers a friend of hers who was a patient in ICU M was actually in a very bad car accident when she was younger and she was in an ICU, and um, she remembers a certain level of consciousness, and I think this is important to know too, and its, I I always think its a pity our patients don't come back and give us feedback on their time in ICU, um, but she said she was still having sleep/wake cycles, though obviously nobody noticed, sort of, you know, she must have still had her eyes closed or whatever. And she said she remembered one time waking up with this excruciating feeling in her hand, and it was enough to open her eyes and they were doing, I don't know, a stab for blood gases or putting in an IV or something, some sort of needle in her hand. She said nobody'd tried to wake her and tell her, um, nobody warned her it was coming, they just did it, and she said it was a terrible feeling, and then she remembers a commotion afterwards so she must have (<i>Mm</i>) put up her blood pressure or something. Um, and yeah, I I can think of a lot of things like that, I can think, you know, there's there's, um, many times when I've orientated new staff to ICU, and you know, when you're teaching them to do things like suction or, um, blood gases, we used to do our own blood gas stabs, um, give injections, all sorts of things, and saying to new staff, "Now tell the patient what you're going to do." (2:8,5-28)</p>
<p>Attempt (viii) (b): Explain limitations to patient - work within limitations</p>	<p>Bryce Y'you know sometimes that how you'd like to lie isn't exactly what (<i>Mm</i>) everyone else's got in mind for you (<i>Mm</i>) um, but you think, "OK, there are limitations, maybe they don't realise those limitations and you best try and try and best communicate those to the patient, but ah, you've just got to try and work with the limitations that you've got and provide that happy little medium (<i>Mm</i>) so, I mean, I.. say a person that, um, has to lie flat but wants to sit up, um, sometimes the happy little medium is about 5 or 10 cms that yes we can sit you up this much but we can't sit you up any further (<i>Mm</i>) but its a big difference for them (<i>Mm</i>) if they can get just that 5 or 10 cms sitting up, it provides a little bit of comfort for them. So if we can work with that then we give, we try and give that (<i>Mm</i>) um, yeah I mean, yeah your patient just can't move at all and and can in a sense show that they want to sit up.(4:5,35-6,13)</p>
<p>(c) Minimising to reduce alarm</p>	<p>After working in the unit for a while, it is easy to see routine things as not consequential And of all the things that you do, like suctioning, sort of the easiest (<i>Yeah</i>) and you just go and do it, (<i>Yeah</i>) you know that that causes them distress and yet that's always when they want to get the tube out and (<i>Yeah</i>) and move around and, like you can do most other</p>

	<p>things to someone (<i>Mm</i>) and they tolerate it but suctioning is something that's (<i>horrible</i>) is just horrible, and you just go, "Oh, a bit of a cough coming up now.", and ram this tube down their other tube (1:10,11-18) Bryce I think there's more discomfort than pain associated with with that than um with a lot of people (<i>Mm</i>) that we realise (<i>Mm</i>) um. I guess the majority of staff haven't had a tube something put down their throat that's ah (<i>Mm</i>) (<i>laugh</i>) (<i>laugh</i>) a half inch in diameter (<i>laugh</i>) to see what it feels like, so um, yeah, can we really sort of like say, "It's all right, you relax." (4:5,22-28) Patrick its like "Oh, look, I'm just doing your dressing here," and its like and your abdomen is right open, you know (5:7,27-29)</p>
<p>Attempt (vix): sedation (a) amnesia</p>	<p>Toni says you often wonder what what people do remember when they're out of it, like whether they actually do remember you going up and saying, "I'm going to turn you now Mr ,," (<i>Mm</i>) you know, or whether that you just midazolam them out, or, you just don't know (<i>Yeah</i>) what they remember. (6:15,10-14) it would also be very individual as well. (<i>Yeah</i>) You know, depending on what they've had, and those sorts of things, to what they remember and (<i>Yeah</i>) you really w' won' wonder if it would be sort of, um, really, not sort of precise, but (<i>Yeah</i>) if they have had lots of midazolam whether they're just kind of guessing at what they felt, you know, like, whether they're just sort of thinking, "Well, yeah maybe I was in pain, or maybe I wasn't." (6:16,24-31) Patrick asks Which which means that that you, i'if you can't remember, do you conceptualise pain? (5:22,6-7) Asha wants to makes sure her patient is not aware of being pharmacologically paralysed I remember one night having a screaming argument with the registrar in another ICU I worked in, um, because he just wanted to give a tiny bit of morphine to a paralysed patient and saying, "You have to give them something sedative as well, you know, all the narcotic will do is just make them drowsy. You can't paralyse someone.." (<i>Mm</i>) and we paralysed this patient just on a bit of morphine and we just had this screaming tachycardia, went really hypertensive and I just said, "We we've got to give them something." and we were just pouring in the morphine, this was horrible, and we just.. he was a huge big islander boy, and he we he wasn't ventilating (<i>yeah</i>) and, even though he was paralysed, he was just obviously a'awake under the paralysis and he was just.. it was really horrible to see him, we were trying to get the morphine in and what was happening was, um, we had the morphine on like a biflow and the morphine must have been running up into our maintenance line. So he wasn't even getting any morphine. Oh, it was just horrible, and we ended up, I ended up just pulling, getting a syringe, 'cause I knew he mustn't have been getting even the morphine, (<i>Mm</i>) pulling the morphine out of the bag with the syringe and injecting it into another port, so I knew he was getting it, and he settled down eventually. But it was just horrible, you know (<i>Mm</i>) and, um, medical staff had gone and they didn't, they just didn't seem to think it was a problem when we told them about it</p>

afterwards, and that's terrible. (2:8,28-9,16) **Rhea** I was warned very strongly actually, not long after I started about sedation and (*Oh right*) and paralysis, just because overnight he hadn't had any sedation (*Mm*) and I was giving sedation and paralysis and he'd been paralysed all night, and I mean right from, I mean I worked in ICU like 5 or 6 years ago now and um, that was one thing that was always ingrained in us (*Mm*) that you never ever do (*Mm*) um, and I kept saying, you know, its always, its always something I did, that you would never, like, could you imagine putting yourself in that position and you know, you couldn't do anything about it. And I actually looked after a man when I, in my first ICU job, who had gone to theatre for the third time and was paralysed and not sedated or analgesed, they hadn't (*Yeah*) because it was a rush back to theatre and they, they, you know, (*Yeah*) they hadn't the time, so this was the guy that took him back to theatre and he woke up and he was writing on the piece of paper, "I was awake, I was awake", and I nearly died, but um he was he was actually a friend of my family (*Oh right*) and knew my father, and I met him since then, and he didn't want to do anything about it because basically they'd saved his life and he walked (*Mm*) walked out of hospital, but he said it was the most frightening experience in his life and he said you could he was mentally shouting you know "Its sore, its sore, stop, stop." and couldn't do anything, so (*Mm*) like I've always remembered that (*Mm*) and there's no way you would never not sedate somebody. And I've never come across the doctors actually asking me to do it. (*Mm*) 'Cause er ah, to me they're all pretty you don't do it (*Yeah*) you just don't do it (*Yeah*) And I don't understand why (*No*) they did that for that patient because there's ways around dropping blood pressure (*Yeah*) and whatever and ways around cardiac problems so (*Yeah*) I think that that would be like living torture (*Yeah, that's horrible*) for someone to be lying there (*Yeah*) and to know that the person at the bedside is doing it to you, 'cause they're not going to forget that. (*Mm, well unless you give them enough midazolam afterwards maybe yeah but*) well, yeah, that's still barbaric (*Yeah, at the time*) its cruel, its horrible. No, I've never I've never had come across that (8:8,8-9,11) **If the patient's pain can't be relieved, then we'd better make sure they can't remember the torture** better for them to be oversedated and analgesed I think, I don't know, statistically if, (*laugh*) (...) what have you read, are patients usually, I mean I guess if someone comes back and says they can't remember it that's a good thing. (*Yeah*) Rather than, "I remember all this pain." (1:16,37-17,4) **Asha has had to remind the doctors of this** fortunately I haven't had to do it too much, well I haven't had to do it at all at this unit, but at other places I've worked just to remind medical staff to perhaps give some sort of amnesic agent, (*Mm*) as well. (*Yeah*) I guess that that comes more into comfort than pain, but though, like you say, its difficult to (*Well yeah,*) separate the two. (2:12,27-33) **Toni** (*Imagine lying knowing and not being able to move.*) Oh yeah, it would be dreadful, it would be terrible I would think.

	<p>(Mm) Mm, I mean that's like people who.. um, you hear stories of people intra-op who, you know, have had the, you know, the anaesthetics haven't worked and they've being fully alert during the procedure but they've been unable to move or talk or do anything, you know, and (Mm) and that would just be terrible. (Mm) You know, it would just be, oh I couldn't think of anything worse. (Do you think that they'd get some sort of indication, like physiologically?) Mmm, you would think they would, but I suppose if somebody's tubed, if somebody's been paralysed and like a an epidural block or something in, (Yeah, then yeah) they probably wouldn't be in pain, but they'd just be awake (Oh yeah) knowing what was going on, (Yeah) you know, but they'd still be tubed and things, and hearing all these things, but not being in any pain. (Yeah) I think that would be terrible, and hearing what people talk about above you in theatre, often not even vaguely related to you, and those sorts of things, you know. (Yeah) Like, one of the girls whose doing my course but doing the theatre part, her research project was on patients who, um, have been awake for procedures, like, you know, how you can have like, you know how they do lots of things that you just don't have to have a general, (Mm) like some of the laparoscopes and things, they can just have an epidural (Mm) and those sorts of things. (Yeah) And she's just going to do the patient's perception of having that procedure and being fully aware and knowing what's going on (Mm) and those sorts of things, (Mm) yeah, and how they felt the outcome was, and whether they felt comfortable with actually being awake when things are going on and things. (Yeah) So that would be quite interesting, I think. (Yeah) Mm. (Whether, I think..) personally, ah, I'd prefer to have a general and be bombed out and not know what's going on, but I think some people choose not to, yeah. (6:21,13-22,15) Petra the patients that do come back and sort of see you before they go, especially a lot of the head injuries and um, that sort of thing remember very very, or absolutely nothing (Mm) of the whole situation (Mm) um and whether I mean that's probably a combination of the midazolam as well as well as just sort of the whole experience. 'Cause, the way I understand it, midazolam um, doesn't just knock off your memory like for five minutes while its working but it has a sort of effect where it (Yeah, it lasts) it um stops your short term memory of things that have happened sort of in the last hour or so as well (10:8,7-17)</p>
<p>(b) patients settle</p>	<p>Leticia realises that sedating this patient makes it easier for her to do her job yes it makes a difference when this patient has midazolam, I can keep them in the bed and they will ventilate and that sort of thing (1:7,8-10) Patrick sometimes we give them a bit of the midaz too. Um, I don't know whether its, I guess it just sort of makes it a little bit easier for us as well. I think its, sometimes its, you know, rarely in our circumstance I think that I can sort of think of instances where, um, you sort of say, "I'll just give this patient some midazolam so he can get some sleep (Yeah) get some</p>

	<p>sleep,” but I think also you’ve very relieved when once they are asleep. (5:11,1-8) Beth sometimes people really like to (<i>Yeah</i>) to give them lots of sedation, but I find especially on night duty that you can give them lots of um, sedation, and analgesia early in the night while they’re fully ventilated and then (<i>Then wean it off a bit, yeah</i>) wean it off (<i>Yeah</i>) but some people don’t its a give it very lightly and then the patient’s really distressed by the morning and then things go wrong. (7:9,10-17)</p>
<p>Outcome of (b): nurses are human and function better if not stressed by restless patient</p>	<p>Which can have its um, I mean I’ve known people to criticise that thinking and like over a period of a shift it can have its positive aspects as well. (<i>Yeah</i>) If you’re not, if you’re getting away from that one instance, if you look at the whole say, ten hours, especially if you think of night shift, I think its a big impact on on what happens in the morning, you know. (5:11,17-22) I think we’re fairly human in that. (5:11,27)</p>
<p>(but) outcome: complication of tension between comfort and life saving treatments</p>	<p>However, some of these patients are too unstable to be turned, are hypothermic and cannot be exposed to a wash, are to be assessed neurologically and cannot be given analgesia or sedation.</p>
<p>simple reaction: take in the whole picture causes goal: balance comfort and life saving treatments</p>	<p>Toni realises that comfort isn’t always our main focus because we mainly have people in the critical phase, its different pain management than people with sort of like a terminal (<i>Mm</i>) illness, um, when you tend to be a bit more liberal with the medications and things. (<i>Mm</i>) And, um, you tend not to have so many hesitations to increasing things and giving more and more, sort of more just so that they are comfortable. (<i>Mm</i>) ‘Cause especially, I think, with oncology patients, there’s no need to be in pain, (<i>Yeah</i>) you know, I’d be quite prepared to give large doses, because they shouldn’t have to be in pain, you know. (6:3,29-4,2) I think, um, we probably have a different, um, perception of thinking, than like like being nurses in intensive care areas compared to nurses who would work in a hospice, (<i>Mm</i>) or work you know on an oncology ward, I think they would have a totally different view on pain relief, different perceptions and everything (<i>Mm</i>). I’m sure they would because, you know, they deal with that sort of thing on a daily basis. (<i>Its their focus</i>) Yeah, its their main sort of, you know, (<i>Mm</i>) sort of primary care type of thing (<i>Mm</i>) just to make people comfortable, and (<i>Mm</i>) I think that would be very interesting, ‘cause I think they would have a totally different view of things, (<i>Mm</i>) you know, ‘cause, um, my grandmother was in the S H Hospice for a few months last year, and we used to come up and visit her and things and the staff were just really really good. (<i>Mm</i>) But they were just really switched on, like you could, you know, like my grandma was, for six weeks she was just very, ah she was pretty much unresponsive like, you know, not doing very much, (<i>Mm</i>) and, but they were still, you could, they just had sort of their own, they were very, um, intuitive I think, (<i>Mm</i>) and they’d you know come and give her some morph and I</p>

would be there and I'd think, "Oh, you know, obviously, grandma's, you know, I didn't sort of think that she would be in pain. (*Oh right, yeah*) Well, I I just didn't really know, you know, 'cause she had, um, brain mets and things and I just didn't really know, (*Yeah*) and, um, but, you know, that's.. they'd come with the morph really frequently and those sorts of things, and they just said, "Oh, you know, we just, we just know." And, you know, I think they.. (*Yeah*) 'cause they see it on such a daily basis, (*Yeah*) you know, they were really really good. (*Yeah*) You know they had no hesitation whatsoever (6:18,20-19,13)

Leticia's theoretical knowledge and experience help her to have an integrated view once you do the course you have a greater medical knowledge and knowing the consequences with people's haemodynamic status like if they're they're a bit hypotensive that you may not give them such a a great bolus of morph and midaz, or you might give them morphine and then give them the midazolam a bit later on or vice versa, um, 'cause having experienced people losing blood pressures and things like that because you give them both at once or whatever so yeah seeing things like that happen you think, "Oh my gosh, I've got to get this patient's blood pressure back up from 50, sort of thing (*Mm*) teaches you not to do that as well or to think twice about doing it and look at their condition as a whole picture and not just oh, they're in pain, but looking at it in the context of where they've come from, like whether they've just come back from theatre and they're hypertensive and so by giving them you're going to treat their blood pressure as well, or if they've just had a massive haemorrhage you know you want to keep them pain free as well, that sort of thing (1:7,29-8,10)

Being inexperienced, Taylor finds balancing difficult I suppose like I just didn't think about I I didn't give, my my patient I had over night was on a morphine infusion or midaz but I didn't give him boluses every time I went to suction (9:17,23-26) Its hard, I mean, this person was on adrenalin too so. (*Yeah*) You're titrating that as well you know you're trying I mean their blood pressure would always go up when you're doing something like that and go back down two minutes later, so. (*Mm, yeah*) I find I find that's hard when being inexperienced and knowing oh, you know, how are you going to do this procedure now and you know, if they're on four like that head guy that's on four infusions and (*oh yeah*) knowing what to titrate and if you if you haven't done a course or something its (*Yeah*) you know, your not that experienced its quite scary. (*Laugh*) I'm just looking up at the monitors, you know, "What's happening?" And you know I have only had one year's general experience (*Yeah*) all up (*Yeah*) and um, its just a whole new learning experience for me (*Mm*) and a little bit scary and anyway.. Like, you know, drugs that drop someone's blood pressure or.. (*Yeah, like they work instantaneously*) Yeah. (*Yeah*) Yeah, so, and especially when they're also with, um, morphine infusion you just, you know. (*Yeah*) But its all, I mean, its all one big learning game I suppose (9:17,35-18,17)

<p>Goal path: Attempt work within limitations causes outcome satisfied that patient is recovering, though uncomfortable</p>	<p>Bryce Its its hard, I mean you you can see.. OK you want this person to get better and the the less that their bud' their body's got to try and put up against th'the better, fair enough, <i>(Mm)</i> but um, is their body going to get any better being in pain? <i>(Mm)</i> a lot of pain? (4:19,17-21) sometimes I think we've got to forgo one thing for the other. <i>(Mm)</i> Ah it, you've got to do your best in that situation to try and and get the best out of both worlds (4:20,16-18) Patrick I e'specially I think in intensive care I think you would sort of, because I think yeah, I guess you would, um, I guess you're biggest concern in intensive care when they're sort of really critically ill is um, their medical side of things, and I think to me that sort of needs to take precedent because um, I don't know, sort of they go off so quickly (5:10,5-10) "Do you want to be painfree, or do you want to be dead?" (laugh) <i>(laugh)</i> I mean, "Do you want to have pain or do you want to be dead?" <i>(Yeah)</i> Yeah, so I think that, and I think ah its, I think it's very easy to meet it, not very easy, but I think its through that its easier I think for some to justify, um, that someone is in a little bit of pain, like <i>(Mm)</i> if if um, as long as that's not for a prolonged period of time, is long that is is for like normally turning or or and as soon as we've turned him they can settle down I think. <i>(Mm)</i> That um, you sort of justify the fact that they're in a bit of pain, yeah. (5:10,16-26) Beth I suppose again there it depends on what their prognosis is, but I tend to give it <i>(Mm)</i> but you know people do come round and say "Well, they're not respon.. they're not purposeful or responding, <i>(Yeah)</i> they're not in pain, <i>(Mm)</i> they're not to have any, <i>(Mm)</i> so then, yeah, I suppose I'm guided by that too, because if one of the doctors comes around and there is one particular one that will come around and say that they're not to have any analgesia because they're not feeling anything <i>(Mm)</i> and he'll say that even with some of the head injuries <i>(Oh, goodness)</i> that have been ah, paralysed, he'd say ah, "Don't give any morphine or midazalam" <i>(Mm, its a hard one)</i> so it is hard <i>(Yeah)</i> um there again, I suppose I'd just go on whether I feel that if they're becoming tachycardiac when I'm turning them <i>(Yeah)</i> and things like that. (7:5,33-6,14)</p>
<p>Attempt (i): neuro assessment</p>	<p>patients receive less analgesia to wake up to be assessed and they are in pain Taylor they just don't I suppose they don't sedate them to see, keep <i>(Mm)</i> make them wake up. <i>(Mm)</i> But I remember one head one head injury the morning orders were not to give them any anything, no pain relief, you know, just just to see what what they're doing, <i>(Mm)</i> which I suppose is is um, they've got to do it I suppose to see neurologically <i>(Yeah)</i> what how much damage that there is but <i>(Yeah)</i> I mean that probably wouldn't be comfortable for the patient. <i>(Yeah, that's the sort of way..)</i> because head injuries are hard aren't they? <i>(Yeah)</i> 'cause they can't communicate and you don't know, you know, and sometimes when you ex'extubate someone they are OK or they're they're just they can speak and stuff they did say that they've been complaining of headaches and <i>(Mm)</i> but you didn't give them anything when they were</p>

tubed. (9:16,9-24) someone was extubated, that that they were, you know, it was a guy or something, but they were OK and um, were going up to the ward but they were saying, "Are you OK?" "Oh no, I've had this constant headache the whole time." (Yeah) "And did you have it before you were extubated?" "Yeah, yeah, yeah" you know, but they couldn't (Yeah) You know, its just so hard to communicate (Yeah) and you know you can deal with it when they're speaking, you know that they've got a headache. (9:16,29-17,2) **Rhea** I think we're pretty good in situations you know like we do have like the head injuries and stuff we do put up morphine and with sedation when we have to control ICP's and things like that and and I don't think that has been missed although there would be a small point where they're trying to assess patients that you find it really frustrating that they possibly, we could possi', we see it as agitation but that could be (Mm) pain and (A massive headache) yeah, oh well, we, and they don't want us to give them anything and that's the hard point, we know what's happening, what can we give them? You know sometimes its better not to give them something that's really important, but we know agitation could not not necessarily just not be cerebral irritation it could be (Mm) severe pain (Mm) and that's one thing that's hard to deal with. (Yeah) And um, you can only ask and if they give you a reasonable answer and a logical explanation as to why you can't, that's accepted (Mm) to a point (Ha) you know, obviously if they're getting really restless they're not around to see it all the time and if they're getting totally uncontrollable and putting going to put themselves in danger (Yeah) then if we give them some sedation I think its important that we consider giving them a small amount of analgesia with it (Mm) which doesn't always happen. (No) and I know its sometimes probably not thought of, and you've got to look, some of these patients can be may be two or three days post-crani' and I know I'd have a big headache after that (Laugh) you would though, I mean, (Yeah) its huge. (8:3,5-33) **Toni** like with our neuro patients, if they're just trying to make sure.. sort of assess their neuro status, (Mm) you don't want to give them too much pain relief in case it bombs them out too much and you're not sure whether they're responsive or (Mm) they're just sort of, you know, too bombed out or there's something neuro.. something else's going on. I think that's when you get a bit hesitant and try and try to refrain from giving lots of boluses and things. (So its sort of a.. like a weigh up thing.) Yeah, what's more important really, isn't it? (Yeah) You know, its sort of especially like with, um, you know, your neuro surgery, or like big head traumas and things, when they've other fractures and things involved with.. I think at times, um, you sort of tend to focus more on the neuro part and, you know, try not to give them lots of pain relief and things, (Mm) because you want to see whether they're alert and orientated, whereas, you know, they've got multiples fractures, obviously they'll be in pain. (Mm) You know, its sort of a ca' (Catch 22) yeah (Yeah) I think. Mm. (Yeah, its hard like that.

Um.)'Cause, that.. I remember, um, just recently we had that Mr, that gentleman in bed 4 who was in the *(Mm)* halo *(Yeah)* traction and *(Yeah)* and he, I think he would have been in a lot of pain, *(Yeah)*'cause he had lots of fractures, but um, they were sort of.. first of all they took the midazolam out of his, um um, infusion, then they used to put it back in and then they tried to have his morphine on a really low rate and things, but, I mean, he would have obviously been in pain that gentleman, you know, *(Yeah)* and turning him and things, especially, they'd all sort of say, you know, "Only give him boluses if, you know, desperately required." and those sorts of things, which..*(Why did they say that? Why did they want it, to give the least amount?)* Because they wanted to see if he was alert and orientated *(Ah ha)* yeah, 'cause they were worried.. *(to assess his head)* yeah. *(Yeah, mm)* But you can see their reasoning behind it but then you can also say, "Well, if he's in pain, you know, he he shouldn't have to be lying there in pain when you're turning him and those sorts of things, just to make sure that his neuro status is OK." *(Yeah)* But its sort of, you just don't, you know, you sort of.. *(Yeah)* Well yeah, its hard I suppose, you.. what's the priority really? (6:4,8-5,13) **Robyne** whether the best course of action is to give them some morphine, and maybe in some instances that's contraindicated. I don't know, for example, neuro patients you're sort of restrained from giving them lots of morphine, so, you know, you have to ah source an alternative, um, a pain pain relief for them. *(So y'what sort of alternative pain relief?)* Ah well ah, panadiene forte, that type of thing with codeine in it, as opposed to a oplate. *(Hm mm)* Yeah, that's not going to make them drowsy. (3:2,10-21) I have a problem with the neuro cases because quite often they'll say, "I want all sedation ceased so that we can reassess them." And I know that's that's necessary, but, you know, that's that's a compromise they're they're waking up, they're gonna maybe be in pain, but we have to assess their neurological status. (3:9,22-27) **Asha** we used to get a lot of traumatic head injuries, you know, kids in car accidents *(Mm)* and things like that, all sorts of things, and they'd want to wake them up after twelve hours or something and they'd be cerebrally irritated, thrashing around the bed, and oftentimes I remember saying, "This kid's in pain, you know, we've got to give him something." "No, no, no, we can't give him anything." *(Mm, 'cause they're neuro)* And yeah, and um, you know, y'l felt that they were in pain because even though they were cerebrally irritated, well I guess, a part of it that I felt they were in pain was because they had broken legs or something as well. But that was it, somebody that had terrible fractures or something like that. *(Mm)* Anyway it doesn't mater what it was, but yeah, because they were a head injury, even though they've just had a stinking great rod put down their femur, you know, and their foot's been crushed and they've got facial fractures *(Mm)* um, because we used to get all horrible things like that, they weren't to be given any morphine, because they wanted to see what they did because they

	<p>had a headache and they'd, as I said, they'd be thrashing around the bed, but oh boy, they must've been in pain, (Mm) as well. You know, you just must if you've got a fractured leg, and as I say, if these people were in the orthopaedic ward and quite compos mentis they'd be given a regular four-hourly narcotic. (2:14,19-15,5)</p> <p>Leticia remembers the patient who was awake and in pain but didn't want the sedative affects of analgesia trying to work out what was the best management for her 'cause she seemed so distressed and so, because she was so mentally capable (Mm) um, you know, trying to preserve her her mental state and yet decrease the pain in the rest of her body was so difficult (Mm) to to give her something that was not going to make her dopey and drowsy and and unresponsive, and I think that she expressed that as well. (Mm) That that was something, that um that was all she had was her ability to to think (Mm) because she couldn't move anything else (1:11,37-12,9)</p>
<p>(but) unclear guidelines</p>	<p>often the guidelines that we have to work in as nurses are unclear, because you you're not sure whether or not they want them completely sedated or you'll have a conflict of um guidelines and that sort of thing. So sometimes you, you know, neurosurgeons might say, "Keep them flat." and intensive care people say, "Keep their ICP below something." and if that means that they're a bit more awake then, you know, what do you do? (1:14,26-34)</p>
<p>Wondering about inflicting pain</p>	<p>Patrick I guess the only other, um, issue that a lot of us, I guess occasionally we look at it and, um, sometimes its almost a bit like this, um, neuro assessment of of people who are really deeply (Mm) unconscious are very deeply sedated because of their injury and, you know, because of their.. also you're doing neuro-obs because of their injury and and I sometimes wonder, um, what it must feel to have that sort of deep pain sort of instilled. (every hour) Well, yeah. sometimes sort of is that necessary, you know, is it is it necessary to do that and is it necess' is it, would it be enough to have a look at the pupils every hour? (Mm) Because I mean, do you really need to know whether somebody's moving their right hand every hour, um, and is.. I guess, I don't know whether, would you stop moving your hand first before you blow a pupil, I don't know? (Mm. Are you talking about the type of patient that's like ICP monitored and on Lignocaine and sedation and..) Yeah they have but I think there's also a a a the then another one another sort of group which where they're sort of like not doing much and, you know, they're been with us for a while and and sort of like, you know, the old needle comes out and you know (ahhh) Aw, (laugh) and I wonder whether, um, that's particularly necessary. (Yeah) I I think its, I think its necessary to do it a few times a day. (Yeah) Mm (Sometimes they've changed it to once a shift or (Mm) on the doctor's rounds but that's generally later isn't it?) Yeah a lot later in a sort of very safe period, um, (Yeah) but I guess then again you sort of.. I guess the</p>

	<p>argument again is, is is it what's the precedent is the physiological precedent or I don't know? <i>(So instead of being are you dead or are you comfortable, (Laugh) its are you dead or will we inflict pain on you to make sure you're not dead?) (Laugh) That's right. (Oh dear) (5:24,25-25,25)</i></p>
<p>Attempt (ii): weaning ventilation</p>	<p>Withold analgesia because tube out is better than no pain Asha says if you can't wean the ventilation because you've got to give too much morphine cause they're in pain, so be it, that's why we have ICU's, <i>(Yeah) you know. (2:14,1-4)</i> Robyne is unsure in this situation but agrees that the tube is better out And what about the situation where the the doctors want this patient weaned, they want them to be on spont in the morning, <i>(Mm) so you're very reluctant to give, ah s' morphine. I always find that a bit tricky too, its like, will I, won't I? (Yeah, so what do you do in that situation?)</i> I have a tendency not to give it, <i>(Mm) because I figure, if they can just put up with a little bit of pain for now, and get that tube out, that'll be a lot better for them. (Mm) Unless its obviously that that's really bad and if its really bad they're probably not going to be well enough to extubate anyway, because there's obviously something else happening (Mm) or, you know? (Yeah) If, you know, they've had chest injuries and they're in so much pain.. (They're going to be ventilated) Yeah (anyway) Yeah, they're not going to breathe up when they're extubated, so (3:11,36-12,15)</i></p>
<p>Attempt (iii): liver and/or renal failure</p>	<p>Withold analgesia argue against grimacing meaning pain Robyne's experience of doctors discounting what nurses see in a uraemic patient they've got that like grimacing, <i>(Mm) and they always say, "Oh its just the, um, uraema, uraemia, you know, (3:12,32-33) its supposed to be quite painful, isn't it, (Yeah) just the uraemic (Yeah) state. (3:12,37-13,1) I remember people have said that to me to, as well, "Oh, its just the uraemic state, don't worry about it." (Mm) Its like, Oh.. (So do they not get any, any narcotic at all, or do..)</i> Oh they do, I I, yeah I remember like them having it, <i>(a bit)</i> but its not taken as seriously I don't think, its sort of like, he was more sort of given it because, you know, you know that huge big wound he had and <i>(Mm) the dressings and stuff like that. (3:13,26-33)</i> Bryce I think sometimes <i>(you just don't know)</i> that doctors oh we all do it a little bit, <i>(yeah) ah, y'you start to look from a different (yeah yeah) perspective, you don't, um, look at the person, you start to look for the.. (the systems getting better type of thing) Yeah (Mm) yeah the um, when I say the medical, I mean the physiological (Mm) perspective rather than the, ah.. physiological sort of includes the physical pain but you start to look at, "OK if you're liver's shot," you think well "OK what are we going to do about that?" (Mm) Um, OK you don't want to start throwing drugs there (Mm) that the (yeah) liver's going to try and break down (yeah) ah and excrete it. (4:19,24-35)</i> Patrick I guess you sort of see sort of you're challenging the liver to ma'metalolize more <i>(Yeah) and I guess the same I don't know, (then if its in failure (Mm) then it's going to (Mm) make it in worse failure)</i> and and then as I say well, maybe at</p>

this point, what's left of the liver we need to save for, you know, if we've got to give drugs like digoxin or or, you know, (*Yeah, or to*) the old antibiotic sort of treatment and stuff. (5:14,28-35) **Leticia's patient** who had malaena and haematemesis, she had been on a sedation infusion of about two mls an hour, very small lady, and she had been unrousable on that, or very lightly rousable, she'd open her eyes, just, and that was it, and seemed very comfortable, and they stopped her infusion to wean her ventilation and she was continually grimacing and when I discussed that with the doctors they said, "Well we don't want to put her back on the morphine infusion because she'll go back to sleep and she has advance liver disease so can't give her panadol, you know", we just couldn't give her anything and I felt really uncomfortable with that, and I was precepting a new nurse and I said to her, "I find it really difficult because I want to, I want the patient to be comfortable and I I feel in a way embarrassed by asking because I knew she had advanced liver disease but I hadn't really thought the whole process through before I asked the question (*Mm*) I just knew that my patient seemed to be in pain, and so I said, "Well what can I give her?" and he said, "Well you tell me what you can give her.", so then I had to think about all those things and, um, he said, "I don't have an answer, I can't give her anything", so", we couldn't and we just had to watch her grimace when we turned her. He felt that she was fairly encephalopic, you know, a bit under anyway, (*laugh*) so it wasn't going to be that much of a problem, but (*Mm*) I sort of, I still felt uncomfortable and I felt difficult about being with a new nurse who I was trying to teach to be the patient's advocate and recognise when they were in pain (*yeah*) and it yeah, I sort of said, "Well, sometimes you just have to ask the question and be told no, but at least you've asked the question." So, whether or not they do that after, you don't know, so mm (1:5,20-6,13)

Patrick I think, when their creatinine and urea just their renal function just goes off, just sort of switch those sort of things off, um. (*What do you think about that?*) Um, (6 sec pause) its a strange thing, because you sort of like, you you're sort of thinking, "Oh god, you know, I should be giving, you know, I should be giving some sort of pain relief here." Um, and again I think its this sort of this this thing that you you've got none of your normal indicators that somebody's in pain that you just, I mean, it sort of seems sort of that it slips into the background a little bit, sometimes you even sort of, ah, forget the fact that you know that he's not on morphine (*Mm*) or midazolam infusion (*Mm*) and um, I guess sometimes you sort of um, when you're sort of at the beginning of the shift, and you're sort of looking through all the infusions, you go "Oh!" you know, "Should I sort of give them a bit of a bolus and um," But, to me that sort of, um, its a little bit easier because you sort of, you know, that, um, physiologically they can't sort of they, you know, its it would be detrimental, would further sort of, you know, um, put them backwards if you did have them on a on a morph and midaz infusion and give them pain control. (5:6,29-7,15)

	<p>Toni I think the reason they not give it why they weren't I assume was because of his renal failure. They thought it would hang around for a long time (6:14,13-15) Rhea I don't know where where morphine and the metabolites go um you know with liver failure, are they just going to the body, um, you know to accumulate (8:13,28-30) that's why, you know, the guys want to stop it (<i>Yeah</i>) after a long time of use and things, um, especially with renal failure I know that its definitely built up in the body um, I'm almost positive its morphine (<i>Yeah</i>) that they don't excrete, which means its hanging around which means that when you do try to waken them up um, and get them breathing, but try and keep them.. you can't find that fine line between (<i>Mm</i>) pain control and like totally knocked off (<i>Mm</i>) because of their you know urea and creatinine have gone off (8:13,35-14,6) Petra B brings this up in his lectures, actually, (<i>Mm</i>) about um, I can't remember it exactly, but basically um, patients, with like an overwhelming type of sepsis I think it was, um, can get that quite agitated look about them but its not that they're particularly um, in pain or, I mean, its mainly the pain um, and that you like, if you keep giving them the morphine then like, I mean I would really have to have another look at it. (<i>Mm</i>) But its its more a response to their actual (<i>septic state so that ..</i>) septic state and the the morphine's.. because they're having like they've got liver problems, and they've got renal problems instead of being able to excrete it they're accumulating it and may more getting sort of more toxic (<i>Mm</i>) by it (<i>Mm</i>) and the more you give them the the worse they actually get (<i>Mm</i>) um, so I mean, I don't really dispute that. (10:6,29-7,7) usually, they're not quite so restrictive with er like if they've got big dressings and what not (<i>Yeah</i>) they'll let you give something for dressings but its to try and avoid this, you know, every five minutes because they look uncomfortable in the bed (<i>Yeah, yeah</i>) Um, (<i>Yeah</i>) and its like CAL patients where you say, you know, they look terrible, their breathing's not good but they always look terrible and (<i>their breathing's never going to be good</i>) <i>Yeah</i> and then yeah, exactly, (<i>Yeah</i>) and um its sort of similar with these types of patients where they're always going to look agitated (<i>Mm, yeah</i>) until they can (<i>Yeah</i>) detox type of thing (10:7,17-28)</p>
<p>Attempt (iv): recovering</p>	<p>Doctors control when analgesia is withdrawn from the patient, yet it may be before the patient is painfree that seemed to work for him fairly well (<i>Mm</i>) when he was on that, and I think that they stopped it when he was getting better. (1:12,23-25)</p>
<p>outcome:</p>	<p>be gentle, hope its not too bad I think it's a human instinct like you said, to a certain extent, you see someone in pain and and you want to stop it. (1:12,33-34) I think, 'cause I don't know that we nurses, I mean, how do you ever know whether , ha! you do that (1:12,11-12) when I don't have an answer to her problem, (<i>Mm</i>) I just have to, how do I reconcile that to myself? Well I've done all I can do, now I've just got to turn her, (<i>Mm</i>) and look the other way, you know, or hope its not too painful or try and reassure her or</p>

	<p>something, and reassurance, you know, its like suctioning doesn't do anything, <i>(No)</i> really, it doesn't stop the pain, doesn't fix it (1:13,5-11) Patrick I think you'd try and do other things like you'd try, you know, your turn is very gentle and and you assess whether, um, he really does need a sheet change now because I mean a sheet change <i>(Mm)</i> sort of tends to be more, you know, sort of really, really painful and stuff so, you try and do other things, um, to I guess, compat <i>(Mm)</i> combat a little bit better, you know, when they're not getting any um, pain relief, from that <i>(Mm)</i> aspect. (5:7,15-22) Taylor so'sometimes they're not on infusions and you think, "Oh, would this person be in pain?"(9:9,39-10,1)</p>
<p>Episode 3: Beginning event: Dying patient</p>	<p>For one particular patient during this shift, a decision was made to stop life saving treatments and allow them to die. Beth wonders if this is still an ICU patient so would you count that as an intensive care patient though, someone who was been extubated and was going to go to the ward.(7:5,4-6)</p>
<p>Simple reaction believe dying is painful causes goal relieve pain</p>	
<p>Goal path: Attempt liberal analgesia causes outcome death</p>	<p>give as much analgesia as possible - they die Petra I suppose the only situations where I've been hesitant about whether they've got adequate pain relief is probably more with patients that we've pulled out on, um, but again its quite difficult to assess whether they've got any pain. <i>(Yeah)</i> Um, and, you know, whether or not we're liberal enough with, in giving them morphine. (10:5,13-18) we had one patient that was quite, um, he was actually quite with it, but with a um, a huge one-sided bleed, I think it was <i>(Mm)</i>um, causing a, I think, extensive paralysis and um damage to most centres but he was sort of looked aware <i>(Mm)</i>and although we sort of controlled his pain to a degree they were quite reluctant to sort of sedate him <i>(Mm)</i>um, although we were, you know, he was incapable of managing his own airway and we pulled the tube and <i>(Mm)</i>um, with the, you know, intension of allowing him to pass on naturally. <i>(Yeah)</i> Um, that, I mean in that sort of situation I just like discussed it with the doctors and if you didn't get a right answer from one you just went to someone higher up and <i>(Mm)</i>um, ended up getting him a midazolam order and in the meantime just sort of keeping his morphine right up. (10:5,23-6,2) I think you've just got to sort of pick a reasonable number and double it <i>(Yeah, laugh)</i>and add one. <i>(Yeah)</i>because basically, you're not going to do them any harm if you give them too much <i>(Yeah)</i> the same, its still going to be the same end. <i>(Yeah)</i> um, but you're going to do them a lot of harm if you don't. <i>(Yeah)</i> If you under, um, under <i>(control)</i> control their pain, yeah. So I always turn in that situation, and tend to go for the more is better, (10:6,12-20) Beth <i>(I didn't know if he was in pain or not. No indication)</i>No indication, yeah, <i>(at all)</i>I can see that point of</p>

view. *(But there's nothing like that that stood out for you?)* No, but in that situation I most probably would give quite a bit. *(Yeah, just in case, yeah)* Just in case. Yeah, I wasn't thinking of that type of patient. (7:4,12-18) Yeah, most are a real comfort issue (7:4,25) **Rhea** that's one thing that I'm very particular about is to keep patients comfortable. Um, although its hard to know where that fine line is to where you're giving that push and they stop breathing. Um, I rely heavily on the doctors to tell me that you know, this is sufficient and its not, *(Mm)* you know, its not the lethal dose *(Mm)* 'cause, I mean, I know ethically its hard for people to deal with *(Mm)* um, you're giving someone something I mean, and I strongly believe its to keep, it has to be given to keep patients comfortable. They may not be experiencing pain, but um, there's a certainly mental anguish and *(Yeah)* things like that *(Yeah)* and especially the likes of that, do you remember that 16 year old boy? I don't know if you would have looked after him. He had the leukemia, um, and his lungs were really shot and they tried the nitric oxide on him for a long time *(Oh yeah)* and eventually decided you know, that it wasn't going to cure anything and and the mask was really irritating him and stuff and so they they spoke to the family and um, up to this he wasn't getting morphine and stuff because he was getting the support of the CPAP and stuff um, and they decided just to let him to let him go and we explained to him and he was in quite you know, quite prepared *(Mm)* that we would give him something to keep him comfortable because he was frightened. *(Mm)* Um, so like the mental anguish of him, you know, sort of terrified of, you know, was he going to be gasping for breath, we said, "No, we will give you the oxygen, we'll just going to take that big thick mask off so you can talk to your mum and dad and stuff." *(Mm)* Um, and that was good, um, I thought it was well thought out and there wasn't a question about it. The doctor you know B came up and said this is, you know, "we're going to give him some morphine and keep him.." Um, we were giving him relatively small doses but enough to keep him comfortable *(Mm)* and as often as we felt it was necessary *(Mm)* Um, you can imagine that it came to that I mean, I know I don't know where that line is *(Mm)* where you're giving that dose and the next thing they're asleep, *(Yeah, Yeah)* but I don't think its wrong um, think its wrong to sort of go along and give 200 milligrams of pethidine and bop them out and then you give them 5 mg of IV morphine you're obviously going to suppress them *(Mm)* anything but um, I think they've been pretty good, *(Mm)* and I know its never been a question of having denied someone to give *(Yeah)* something um, analgesia in a case like that. Um, in the majority of times it is for mental anguish.

And I have looked after a cardiac arrest who they had they decided they were going to pull the tube and um, we gave him regular morphine and he sort of lingered on for an hour or two *(Mm)* and given regular morphine, um, and I thought that was excellent. And I never been I never noticed it to be a

problem, and I've looked after a few that they've pulled out on and they're very good. (Mm) (8:20,2-21,19) (...the sort of patient whose dying I just don't know how much to give them.) It's the same, it's that fine line. Um, I don't know, I'm trying to think how often (how often, or how is it sort of like by the clock thing or whether you just look at the patient?) No, no it's looking at the patient definitely not by the clock. As I said, it's just looking at the patient, I mean, I was going to say something really stupid. I mean, you know, this guy um, sort of, um, started to, he had been, we started off giving him just an initial dose just to be on the safe side because he was going to be comfortable an initial dose of morphine and then after a while, which I'm sure was probably due to the fact that he was cheyne stoking and stuff but you know when you sort of feel that they're, it is, it's you know you sort of feel that they're fighting (Mm) um, I'm reluctant to say gasping for air, because, I mean, (Mm) the they're dying, and if they're cheyne stoking that's just part of the you know, intermediate stages but that sort of you know what I mean and you think that they are fighting (Mm, so they're uncomfortable) Yeah (Yeah.) And so you give them a dose then and it's certainly not by the clock, it's because you see it. (Yeah) That's why you have to be I'm always very wary of um, becoming too hard (Mm) I mean, it hasn't as yet, I mean I'm just as soppy as ever being in that unit and it can be very hard (Yeah, yeah) but um, I'd hate to think that some .. 'cause I know some people will get (Mm) and you know can be hard (Mm) although the girls that we work with I think are great (Mm) we've still got our sense of emotion (Mm) and there's none of this "Oh, you know", kind of thing, "they're dying, that's it, go ..." They're all very good. (Yeah) I think that's something we should all watch out for too, getting too hard for something. "Oh, no, no, no, they can't feel anything anyway" you know. We've always got to be aware (Mm) But um, you know, I think they're pretty good in situations like that. (yeah) and yeah, it is the same so... But to keep yourself right, you could, I mean, if you were new but then you wouldn't know but (Mm) then you could do it by the clock or get one of the doctors and say "Look it was so and so a time since I last gave it, what do you think?" If there's no (Yeah) you don't know and there's no guidelines and (Yeah) the fine line giving them that little bit and they stop breathing. (Its a bit scary) It's just I think (Its scary for you) it's my Catholic, (Yeah) Catholic upbringing you know you sort of think, God this one dose is that enough, you know, (Yeah) and you sit and watch you know, television and they tell you you know you can't do these things and but then they talk about lethal doses (8:22,7-23,21) **Robyne** Essentially, um, they said, this guy was requiring so much adrenalin they'd pulled out and he didn't have any family, but that's a whole another issue. (Yeah) You can't.. O.K. you don't have any family, forget it, um, so they said, "Well we're ceasing treatment." So I turned the ventilator off, I, um, turned it down to 30%, his saturations were, you know, about 40, turned all the stuff

off and I gave him [amount] of morphine in half an hour and he was dead in about [amount of time]. (Mm) And I had no qualms about doing that at all. I know that dose probably killed him, but he would have lingered longer if I hadn't have done that. (3:7,5-15) I mean, in that instance I wasn't going on his grimacing, (Mm) I was thinking how awful it would be, how awful it would feel for you to be conscious and knowing that you were about to die, (Mm) and I didn't want him to experience any pain whatsoever in that (Mm) time, (Mm) and that's why I did that. (And even..) And I, y'y and and because it was so hard to tell, it was so hard to tell whether was experiencing 'cause he wasn't doing anything (Mm) Um, you know, it was like, "You gonna die, I'm not gonna let this pain, you know, linger, (Mm) make it longer." (3:7,18-28) I mean, situation on the ward too, I remember a lady who, you know, she was dying of cancer, and she was basically scoring about three on the Glasgow Coma Scale, and she had a KVO drip up, and she was alive for about two days just getting the regular doses of morphine that she would be, and, I mean, that's a †tragedy (Mm) I found, you know. (Mm mm, I g'guess that's another whole debate) But in, you know, in my, in those instances where they weren't grimacing, because their conscious.. level of consciousness was so.. (But you knew when that they were going to die) Yeah (anyway) I you know, I would have loved to have intercepted and given them more, but (yeah) I wasn't offer.. I wasn't in a position to do that. (Mm) When I was in a position to do that, I did it. (3:7,31-8,7) **Asha** I've been in that situation you were describing before about giving um, enough morphine to kill somebody, well and N and I have spoken about this, you know, and we were saying (sigh) (4 sec pause) there is a fine line between what you perceive perceive to be enough to take away their comfort and what is too much but I think there is also a point where it's obvious that you've overcome their comfort problem. (Mm) You know that they are comfortable they're, you know, solminent. (Mm) Um, and, 'cause I had a man like that. Remember that, were you on that night when I had that man in bed one and his wife helped me wash him (Yeah,) at the end of the night (Yeah) Yeah (Yeah) and um they were just on the evening shift pouring morphine into him, pouring it in and that man was barely conscious. (Mm, mm) He was comfortable, you know, (yeah), but he was alive. (2:13,6-20) **Toni** a gentleman here who we put him on the trachy mask, and he was our long term Mr. N? (Mr. N. rings a bell) Mm, long term CAL. (Oh, yeah, yeah) Yeah. (Yeah) Here for ah five weeks or something, and I d'.. we decided on my shift that they were going to withdraw treatment and put him on trachy mask and things, and we, um, just kept giving him heaps and heaps of morphine and things and lots of midazolam and.. (Mm) So I think he was quite comfortable and that the orders were quite liberal, (Mm) as to what we wanted, and I had no hesitations in giving him, you know, frequent doses, (Mm) 'cause, um, 'cause he'd got put on the trachy mask, he started getting quite distressed and you could tell he was

just distressed and, you know, uncomfortable. (Mm) So I had no hesitations and the medical staff (yawn, excuse me) were quite happy to keep.. sort of, you know, giving as much as we thought. (Mm) So that was quite good. (Mm) That was managed reasonably well, but you could tell he was uncomfortable (Yeah, just 'cause he was having, like, struggling to breathe) struggling to breathe (Yeah) and his resps rate was up like around the 50 mark, and (Yeah) he was really sort of shaking a bit, yeah (Yeah) grimacing and you could tell he was just, you know, getting very distressed and uncomfortable, (Yeah) 'cause he got really tachycardiac and you could yeah (6:17,8-31) **Taylor** I was up working on Neuro and we had a lady that was.. they knew that she was she was dying, you know, she was not NFR or whatever, (Yeah) she | | actually, I thought she'd go on my shift and and it was a big Greek family, they were all in there with her and howling, you know, (Yeah) which is fine, its their way of dealing with it, but I remember, um, I was in there and and the relatives, the daughters and that were asking, you know, "What's she doing now? What's she doing now? Is she.." and I don't know if you've ever seen seen a patient type of, they jump (Um) but they're still (Yeah) they're still going (Yeah) like their not dead and I thought, 'cause I'd never seen it, it was my first dealing with that experience, so I didn't know if she was still.. I had to go up and feel (Yeah) the pulse to see if she was still, ah, (Yeah) there and I, and the daughters going, "Oh, is she still alive? and I'm going, "Yeah, yeah." But I found that really hard 'cause they were, the whole time they were going, "What's happening now?" and "When's she going to die?" "When?" you know, and she had a butterfly in her arm, so I was just giving her, she had PRN boluses any, like any PRN like, (Yeah) there wasn't any time limit, (Yeah) and I | | just, 'cause I hadn't worked with her, I didn't know how PRN I could, like how much (Yeah, how frequently, yeah) how frequent I could give it like and I remember just going up to the doctor and, I knew, I mean, they knew she was going to die soon (Mm) and could see that she was in pain and I just didn't know, like if that little bit I give, I gave her would pull her, or push her over the edge or (Yeah) I found it really hard (Yeah) and then then the family being there and, you know, "What are you doing now?" and, you know, practically I was giving her her last, you know, (Yeah) bolus. I wasn't killing her but I was making her comfortable. (9:12,36-13,32) And this person, she was in renal failure, she wasn't responding, she was just laying there (Yeah) you know, just gasping for every, (Yeah) you know how they do. (Yeah) Its very distressing to watch and the family were there and, ah, yeah, so | | | | actually had to go and query with some of the senior staff or the doctors, how how frequent PRN could I give it, like (Mm, yeah) you know. (9:14,1-7) I suppose, if you get, if you're covered legally (Yeah) that's fine, but I just didn't even know, this was my first experience (Yeah) I didn't know (If you were covered legally, yeah) could I give it, could I give it just ten minutely or half hourly or (Yeah) two

Appendix W
Collective story in four episodes – *creating four episodes*

	<p>hourly or <i>(Yeah)</i> there was no order written there like. <i>(It was just PRN)</i> PRN <i>(Whenever you thought)</i> Yeah, and I found that just a bit hard to, um, <i>(Yeah)</i> to work out and she ended up dying soon anyway, but it was, it wasn't the nicest thing, <i>(Yeah)</i> having the relatives there and asking, "What's happening now?" and you don't know, like I'd never seen, you know, I don't know <i>(Yeah)</i> you know, they, I mean they were saying, "Is she in pain? Is she in pain? Is she in pain?" So I'd always say, "Well, you know, she looks comfortable." <i>(Yeah)</i> She did look comfortable but how could you say? <i>(Yeah)</i> Like you know, <i>(Yeah)</i> she wasn't con', she was lying there, gasping for breath, you know <i>(9:14,13-29)</i> Taylor there was another lady, I think it always happens to like those.. she was like a bag women, <i>(Oh yeah)</i> she was in ITU and hadn't, obviously a street women but hadn't kept, you know, <i>(Mm)</i> kept herself very well and and it was like the doctors didn't care as much about her as the other patients, like they didn't, <i>(Mm)</i> they knew she was dying and she wasn't, she was NFR but like they didn't write up, he didn't write up, they didn't write up pain relief <i>(Mm)</i> for her in her last and I remember o'one of us had to go and ask the doctor's to write her up something, 'cause she was NFR but she was still, she was, you know, she was lying there, <i>(Yeah)</i> just deteriorating, just rotting away and had no pain relief and like every other patient had it. <i>(Yeah)</i> I just found that a bit, you know, <i>(Yeah)</i> I think that those type of physical, social stuff come in to how the doctors treat people <i>(Yeah)</i> like, I think it does in a way. <i>(It does, yeah)</i> You know, <i>(Yeah)</i> social <i>(Social)</i> aspects <i>(Yeah)</i> and that sort of stuff will ah, 'cause we had to go and ask for her to be put on, have pain relief <i>(Yeah)</i> and a bit of dignity while she died. <i>(Yeah)</i> So. <i>(Its sad)</i> And that was in our unit too. <i>(9:14,31-15,14)</i> I mean the doctors shouldn't have, they should treat everyone as, um, <i>(Mm)</i> you know as equal patients, I know it doesn't happen you can see it <i>(9:15,20-23)</i> they were just um, um, the ones that swap around but they should have written up pain relief for her, <i>(Mm)</i> just to die comfortably, that's <i>(Yeah)</i> she was dying anyway. <i>(Yeah)</i> You know to be comfortable and <i>(Yeah)</i>. <i>(9:15,28-31)</i></p>
<p>Outcome</p>	<p>Beth And I think its just to make us feel better too. <i>(Yeah)</i> that you end up giving <i>(that they're covered)</i> you're giving that morphine, although some people are reluctant to give it. <i>(Yeah)</i> They say "Why am I giving this 'cause I can't see <i>(7:4,29-32)</i></p>
<p>Episode 4: Beginning event: Brainstorming session</p>	<p>At the end of their shift, these nurses were asked to attend a brainstorming session on possible ways of improving the whole issue of comfort in non-purposive patients.</p>
<p>Simple reaction think its a worthwhile topic causes goal contribute ideas</p>	<p>Petra everyone seems to be open to suggestion anyway. <i>(10:8,34-35)</i></p>

<p>Goal path: Attempt put forward suggestions causes outcome increased awareness</p>	<p>increase awareness/objective measure for assessment/creative/assertive/education</p>
<p>Attempt (i): education</p>	<p>Leticia reminisces about her first experiences in the unit thinking that more education would help in this area of nursing there was never any education as to the reason why it was at that point it was only because you ran an infusion at two mls an hour and you saw that they were still awake and uncomfortable and distressed when you moved them that you realised that you should turn it up to to five mls an hour.(1:2,7-12) I think lots of education around the place is a good thing, and um, yeah, I think that we don't get much edu..like we're taught about what the drugs do and how they work, but we're not really taught how to use them, I don't think. (1:4,29-33) maybe education in those sorts of things (Mm) is where it would be more helpful rather than how to use the drug, a bit more about how to expect the patient to respond or something. (1:13,35-14,1)</p> <p>Bryce agrees I guess the only other thing is more education and stuff like that (4:22,24-25) educating staff (about)um, I think, OK we learn about um arrhythmias and (Mm)and the effects of this and the effects of that (Mm) but I haven't um had a pain session yet um, hopefully this will be good once this is finished, um (Mm) we've paved the way to ah, a couple of ah, in-service educations perhaps specifically directed at um, people that um, are non-purposeful and (Mm) how we, how the staff perceive that pain (Mm) um, and ways you can overcome that pain (Mm) um, for the patients because I mean, yeah there's pain management things out on the wards, for say the oncology wards and the orthopaedic wards, they would like do do you give them enough pain relief but um, that's a little more, that's a little easier to to assess up on the wards and they haven't got a tube jammed down their throat um. (yeah) So, perhaps that's why no one's sort of touching it I guess, because its too subjective. (Mm)Um, you know the old M brain-storming situation might be a good idea for something like that. (4:22,27-23,7) But Leticia concedes education is not a panacea oh how could you teach someone? Cause I guess in a way its so experientially based, like you need to see, and a patient on one mg of morphine might be almost unconscious and somebody else on five mg might be climbing out of the bed (Mm)so you can't say, "Start you infusions at two mls and hour and increase them, you know, in hourly increments of one ml." and that sort of thing so yeah, to to be that rigid isn't really possible either, but um, yeah, I guess, yeah, there maybe aren't definite answers (Mm)for that, but um, maybe maybe its an awareness thing for the staff (1:5,4-13) Bryce agrees its definitely a talking issue.</p>

	<p>People've all got different ideas on <i>(Mm)</i> how some pain should or shouldn't be managed so (4:23,30-32) Toni thinks experience is the best teacher I think it is all experience, definitely. <i>(Mm)</i> Some people are just, if you've been nursing, you know, fifteen years or something, you know you should, well theoretically, you should be able to sort of assess if your patient's in pain, a lot better than someone whose only been out a few years. <i>(Yeah)</i> But that just depends on your experience I suppose, <i>(Yeah)</i> and whether you're a bit more intuitive (6:19,20-28) Beth agrees Once again its just experience that you know (7:3,1) Rhea that's from experience that you learn that <i>(Yeah)</i> and listening to other patients with different conditions. <i>(Yeah)</i> Its not something you just know <i>(Yeah)</i> its listening to other people. (8:4,22-25) The information gathering is from experience definitely <i>(Yeah, yeah)</i> I don't think that's something, nobody can teach that, (8:5,1-4) I mean that's all you can do, you've just got to learn, it its all experience learning and there is hit and miss with neuro <i>(Mm)</i> especially if they're paralysed (8:7,27-29) Patrick reflects on the interview I enjoyed that and I think you sort of, I mean, stuff like that sort of makes you sort of think about.. <i>(Yeah, makes you think about, brings it up to the front of your brain a bit)</i> Yeah, (laugh) <i>(laugh)</i>, out of auto pilot. (laugh) <i>(laugh)</i> (5:26,7-11) Rhea its certainly food for thought (Laugh) <i>(Laugh)</i> your eyes opened. (8:14,18-19)</p>
<p>Attempt (ii): bring patients back to talk about what they remember</p>	<p>Patrick I guess to gain more idea about it maybe we should look at, oh I guess, oh I guess you could always do it on a voluntary basis but maybe ask more, get their side of the story more (5:21,26-29) I guess, it would be, it might be interesting to sort of, um, and I guess we never sort of all do that, where we sort of get patients who've we've had in for a long, or like for a reasonable amount of time and and talk.. get them.. <i>(Mm)</i> like talk to them about their experience in depth. I do know some of them come down and say, "Oh, thanks very much." But then.. <i>(So, you haven't heard any patients come back and talk about anything in particular.)</i> Um, (cough) oh, they've come back and they've talked about it and said, that you know, "Thanks very much and we got really good care here." Um, but I guess it would be interesting to to ask them specific questions about whether they were in severe pain at any stage and, um, did they feel pain, but were unable to com.. um, like communicate that they were in pain and and stuff like that. <i>(Mm)</i> (Cough) Whether they're at that time would be honest with you could be difficult to say, because it <i>(Yeah)</i> be pretty hard to walk into a place like that and say, "Oh, guys, (laugh) <i>(laugh)</i> you're doing it all wrong." (laugh) <i>(laugh, yeah)</i>. (5:4,14-32)</p>
<p>Attempt (iii): effective assessment tool</p>	<p>Leticia offers maybe having a more effective tool that's less, um, subjective, but then if someone's unconscious there's no way that they can can tell you, but I guess you go maybe using more physical signs of grimacing or or um you know localising to pain maybe something like that would be more effective than <i>(Mm)</i> standing at the end of the bed bed going, "Oh, they seem to have mild pain."</p>

	<p>(1:15,2-8) Robyne is more specific in her suggestion of an effective tool I think its an important area to address, but until a tool has been used that, oh a tool is established that is accepted and helps rate the pain level of the patient, if that's possible, there's still going to be so many variations in treatment. <i>(Mm)</i> Pain is subjective, but it somehow has to be measured fro people to be able to treat it effectively. <i>(Hm mm)</i> Doesn't it? If its like on a scale of one to five, your pain's a three, so you need pain relief. (3:14,3-10) Maybe, you'd hav'.. it'd be .. it'd take a hell of a lot of research, you'd have to, you could do it, you'd have to like invent a like computer software package to do it, and take, get, take everyone's statistics from every operations and get them to say, "Oh how much pain did you experience?", and at different stages and somehow come up with this thing in the end which says, OK. you had a carotid endartectomy, you should be experiencing this certain.. you know and then like is that applicable, I don't know. God, I don't know, <i>(Laugh)</i> I don't know.(3:14,14-24) Patrick suggests Maybe we could have just like a little BSL with like have a endorphin sort of easy test (5:23,6-7) but Patrick concedes I guess its difficult because everybody experiences it differently. <i>(Yeah, even if they could measure it whether the actual experience is, cause its to do with perception as well)</i> <i>(Mm)</i>, and it would change from, like from day to day, and sometimes you'd have a really positive day and you can sort of put up with these things <i>(Yeah)</i> sometimes you just go.. <i>((laugh)Yeah, so we continue to guess)</i></p>
<p>Attempt (iv): use experts</p>	<p>Leticia suggests its difficult to know <i>(Mm)</i> what what to give and and what to recommend, and maybe, I don't, maybe using the pain teams more often would be more effective (1:12,17-18)</p>
<p>Attempt (v): preop patient visit</p>	<p>Leticia thinks that a pre-op visit might help patients be more comfortable in the unit I think at the time we were trying to be more open and and keen to get patients to come down and see the unit so that when they came around post-op they could see, you know, have a bit of understanding about what they were going to experience (1:10, 35-11,2) its like everything if you've got some, if the fear of the unknown <i>(yeah)</i> is an incredible thing so if you've got no idea, at least if you wake up you feel this thing in the back of your throat, you might somehow think this is the tube they were talking about. I mean, maybe there's a connection, <i>(Mm)</i> maybe there isn't, I guess you don't know, the individual will respond differently. So maybe if by just - maybe if one in ten <i>(Mm)</i> was helped by it we should make a greater effort to do it. <i>(Mm)</i> but that's a time thing as well. <i>(Yeah)</i> That's something that really the wards need to initiate, not us, 'cause they're the ones that have <i>(they have the patient first off)</i> yeah, preplanning the care <i>(Mm)</i> and they're creating clinical pathways and things like that that's the stuff that should be built into <i>(Yeah)</i> into clinical pathways. (1:11,10-24)</p>

<p>Attempt (vi): changes in nursing practice routines</p>	<p>sometimes I think that I'm not so good at concentrating my activities to a certain, like trying to concentrate them at one point in the hour, instead of taking the whole hour to do all these things and continually going back to the patient and disturbing them (1:4,4-8) Bryce talks about protocols I think sometimes we we depend too much on protocol, protocols are good, um, but you've got to go outside of protocol as well, (Mm) um (Turned tape over) Look at the person again (Mm) 'cause the protocol's designed to, as a safeguard and it should be kept as such and observed that but you've got to go go outside of that occasionally. (Mm) I mean rules were meant to be broken(laugh) weren't they? (laugh) As long as you keep the patient safe and well and (yeah) ah, and all those considerations. (4:17,36-18,8) Patrick we could be a little bit more pro-active but then I think there's also, um, (4 sec pause) people are probably a little bit afraid of of what the reaction is from, um, (B, laugh)(Laugh), from the medical side (5:9,37-10,3)</p>
<p>Attempt (vii): alternatives</p>	<p>Bryce suggests holistic care perhaps we we should look at, if we do get someone who's say of an alternate lifestyle (Mm) is, OK morphine may be good, but is, um, a bit of aromatherapy and a bit of say their friends talking to them even if this person can't communicate back, is general chat and and relaxation tapes going to be of, um, benefit as 2 mg if IV morphine? (4:11,12-17) Bryce volunteers that alternative narcotics and analgesics should be considered, but choices based on research I guess alternative uses of things as well, (yeah) as we mentioned earlier. (that we don't think about) Um ah, do yeah, do we specifically need to use morphine for ah, every case, I mean, excluding those that are allergic to morphine, perhaps ah, if we use a pethidine infusion for perhaps pethidine may have been linked to a better management of um, I don't know this but um say abdominal surgery say the better manager of abdominal surgery whereas morphine is better for orthopaedic or visa versa (Mm) if we, so OK, we might use pethidine in orthopaedic patients because the majority of studies have proved that, like Panadeine forte is better for skeletal like bone pain (4:23,14-26) Patrick agrees You know, I think we should look at, um, because I know, a lot of the time when people wake up and like, there was a case the other day and we still tend to try and say, even if they've just got a headache like from the operation still give 1 mg of morphine, and.. (What was the one the other day? Was a..) Oh, it was a um, it was a crani, oh an aneurism that they didn't um, didn't end up getting, (Oh yeah) and she was um, fairly much awake and stuff and and um ready to go to ward, and she was just simply, just wasn't a bed and um, you know, had a headache and one mg of morphine (ha) and (Yeah) and sort of went st'.. (Normally, on the ward they might get panadol) Panadeine forte, yeah, yeah,(laugh) (laugh) or panadol, yeah, just a panadol and I sort of, I sort of started with, sort of, I thought, "Oh, isn't there something else we could</p>

give here like,” and I thought, “Oh, panadeine forte,” and I thought, “Oh, do we have any panadeine forte on the ward?” *(laugh)* I had to check whether we’ve even got it you know, its like *(laugh)* *(sigh)* so, ummm, *(Yeah, we’re so narrow-minded (laugh))* But its its um, it is it is narrow-minded, its its a routine of the thing, its just like which is not just its just an ex’.. its not an excuse its just an explanation, I think, *(Yeah)*. and I think it’s, just just, I think we need to sort of continually try and sort of be a little bit more um, creative *(Yeah)* which is not, which is not encouraged from the medical side again, either. (5:17,3-30)

Patrick thinks nurses could encourage a look at alternatives I guess it could be nursing initiated, the fact that we could say, “Well, um, in the incidences where this is not appropriate, or where we could use something else.” Um, then we could have another protocol on standby, *(Mm)* that where then, so we don’t sort of go willy-nilly with anything, but we say “Well, you know, this is another option for us.” *(Mm)* Because I think B is very much , he’s very much um, ABCD, you now, you know *(Yeah)* and if and so if if G is not in the options then you know, you just don’t use G *(Laugh)* *(laugh)* its not, you know. *(laugh)* which has, I mean, he’s he’s got his point, I mean there’s some very good reasons for doing that *(Yeah)* but I think there comes a point when we say “Well, maybe we should look at G or not.” (5:18,23-19,2) Toni been to a few lectures with like pain management teams and things, which is always very interesting, *(Mm)* you know, and there’s so many different ways you can control pain, like you know, just doing like femoral blocks for legs and those sorts of things, just gives you a bit of a broader idea as to *(Yeah)* what sort of things they can do, you know, *(Yeah)* like there’s lots of ways you can give pain relief without necessarily just having, you know, morphine drip running, those sorts of things, so there’s lots of different methods which often get overlooked, *(Yeah)* you know, and um, we ‘cause, we used to use lots of, um, you know if you get big fractures and things, you know, femoral blocks or brachial blocks and things if you’re putting arms back into place and those sorts of things, and they seem to be quite effective and I think just being able to see lots of different methods and ways that things are done, you sort of.. broadens your *(Yeah)* ideas a bit more about pain relief I suppose. (6:8,4-20) Rhea I mean we don’t have omnocon omnocon at all. That doesn’t.. we don’t even stock it. *(No)* I mean, I don’t know why, its just gone out of vogue or they just, maybe there are problems with metabolism I don’t know. *(Yeah, it just seems..)* and, another one that they never use well there is Torodol which came out on the market about four years ago, three years ago, non-st’.. *(Is that oral?)* Non-st’.. No, its oral plus its um, IM, *(Mm)* I’m not sure if they actually, it could be because, I don’t know, if they can give it IV or not. But if you consider our long term patients why can’t we give them a regular IM, its a non non-st’.. *(A non-steroidal)*, yeah an anti-inflammatory *(ah ha)* and it works in the equivalent and it works quite like morphine and and pethidine and stuff

	<p>and I used to use it where I last worked. I know to begin with, when it first came on the market there were problems with bleeding but that has since you know <i>(Mm)</i> not been a problem, and I know, I don't know if they even use it in S.V. <i>(I don't know, you'd have to ask a pharmacist)</i> but that seems to have gone out of vogue because there were one or two problems <i>(Yeah)</i> at the initial stages but I mean, as far as I know, that was resolved because I'd spoken to some reps about six months after that. <i>(Yeah)</i> It's not used. It seems to be that they did not tend to consider new drugs on the market, not that there's a lot to compete <i>(Mm)</i> on a regular basis but morphine and pethidine and stuff but there's nothing in between. (8:14,25-15,14) I even find with the PCA's, they go for morphine and don't consider pethidine a lot, um which we we used to um, <i>(Mm)</i> we used to play with both, depending on what was more effective for the patient <i>(Mm)</i> and they don't even consider, its just they'd go straight for morphine every time. <i>(Yeah, B's a bit like that though isn't he, if you know a drug, use it, don't use anything else because ah ha, yeah)</i> Yeah, but although, we should be ones that do a lot of research and a lot of um, trials of different drugs because we are a a big teaching hospital, and you know, we're a big unit we should be more into it <i>(Yeah)</i> but I'm telling you, (8:15,21-32) Petra usually morphine and midazolam <i>(Mm)</i> um in most cases anyway, and that sort of covers your pain and your um sedation. <i>(Mm hm)</i> Um, (3 seconds pause) we tend to use morphine because its easy to titrate and its.. can go in an infusion and is cheap as opposed to sort of fentanyl or anything else. (10:3,18-23)</p>
<p>Attempt (viii): epidurals</p>	<p>Patrick I guess I was thinking about that yesterday, I sort of yeah, sort of, um, yeah, sort of um, gone right past the epidural <i>(Mm)</i> and and um, but then the type of patients you're talking about I guess how do you assess <i>(Yeah)</i> what the epidural is doing <i>(Yeah)</i> if its creeping up a bit much, (laugh) <i>((Laugh)) Yeah, they can't breathe (laugh))</i> yeah, (laugh) <i>(Lucky they're ventilated.)</i> actually on the ventilator <i>(or not moving at all so are they paralysed?)</i> Yeah (laugh). "Can you open your eyes?" "I could, you know, I would if I could." <i>(Oh, dear!)</i> Um. <i>(laugh)</i> (5:15,9-19) Toni , I think epidurals are quite good for pain relief for sort of like triple A's and things, 'cause you can sort of get them up and mobilise them quite quickly. <i>(Mm)</i> Yeah, quite good. <i>(And we don't have them much)</i> We don't use them enough, <i>(No)</i> I don't think. <i>(Yeah)</i> I think, I know that um, some of our doctors don't like them, don't like them very much, but um, I think they're.. I mean I've seen them used quite a bit, <i>(Mm)</i> and especially with triple A's and, um, other sorts of big abd'abdominal surgery and things, lots of gyne and things, they use epidurals. And that, I mean they're really great, you know. <i>(Mm)</i> And I I think some people don't really understand them very well, like they try and give sort of break like, give them boluses of morph and things whereas they should be turning up the epidural and those sorts of things. <i>(Yeah. Does it.. e'epidurals for this type of patient, do they</i></p>

	<p><i>use them, for the triple A's, do they use them like from theatre onwards?)</i> From theatre onwards, <i>(Yeah)</i> yeah. <i>(So)</i> So when you're weaning them and things <i>(Mm)</i> to get them extubated the.. early the next morning, <i>(Yeah)</i> first day post op, <i>(a lot quicker)</i> yeah, 'cause then they'll actually they'll, you know, they'll breathe up better, they'll do their deep breathing things, 'cause, you know, they've sort of got, they've got, they're sort of um, <i>(the area of the operation's...)</i> localising, yeah <i>(Yeah)</i> that area, <i>(Yeah)</i> which is good, they can actually get up and walk around, whereas, often if they're on morph and midaz they're a bit bombed out. They don't tend to sort of respond as quickly. <i>(Yeah)</i> Suppose its just different. (6:2,32-3,24)</p>
<p>Experience as a nurse</p>	<p>Rhea people don't move from area to area which means they're not going to get any widespread experience <i>(Yeah)</i> but I think the thing to do is to go from different situations and learn <i>(Yeah)</i> and pool your knowledge when you get to somewhere where you're happy to stay <i>(Yeah)</i> and utilise everything that you've seen before <i>(Mm)</i> but um, some nurses that come out now don't, they just get there <i>(they stay)</i> and they stay and they leave and they go off travelling and they come back and they stay and they don't have any other experience. (8:17,11-20) we did thirteen weeks <i>(everywhere)</i> and you went to medical and surgical at least two or three times and you got a good idea of what was going on <i>(Mm)</i> and that yeah, I think that's the best way to do it but its not going to happen. <i>(No most people do whatever they want to um...)</i> But its never looked too kindly when you're jumping from area to area either, you know, in your in your CV I mean you just sort of do a year here and then you jump and I mean its all right to sit in an interview and say but you know I was interested and want to gain knowledge in different areas and it was you know, you're jack of all trades and you're not good at anything and so people look now and see if you're going on to get your degree and get experience in specialising in a particular area (8:18,2-15) I would have to say that our hospital training would have to be the best. <i>(Yeah)</i> Yes, I'm biased. (Laugh) <i>(Yeah)</i> Oh especially ah um, this new university um, they're planning to, after you you qualify get your degree and they're planning to do you can stay on one more year and specialise <i>(Oh, I don't know of that)</i> 'Cause I know they doing a certificate program in the university starting next year for the ICU course and you know how its a two year base course now? They're going to reduce that down to a one year certificate. <i>(Yeah, can you do that straight away after your degree before you even work?)</i> Well I know that was the plan with Project 2000 over in Great Britain, that was what their plan was <i>(Yeah)</i> that you would do one further year and that would be you know you'd do the .. psych, Midi, children's, and that well I don't know if that's what actually happened I never learned, you know, whether that's a bad move or whatever, but that was certainly the plan. (8:18,26-19,6)</p>

Doctors come around	<p>Toni I think they normally come along just when you've given them a bolus or something, 'cause you've turned them and they think that obviously (<i>Its like that..</i>) they've been like that all day. ((<i>laugh</i>)<i>Yeah</i>)(<i>laugh</i>) Just, they come just when they're, you know, (<i>laugh</i>) you've given them that little bit too much of morph and they're asleep, then they say, "Well that's it, no more." (<i>laugh</i>) You know, and you just think, "Oh, (<i>laugh</i>) if they were there for 24 hours, they they'd know that this person is uncomfortable and (<i>Yeah</i>) is fully with it." but, you know, yeah its hard. (6:5,20-29) even when you're suctioning people and things, it must be really awful (<i>Mm</i>) and uncomfortable and, yeah when, yeah, I mean, if you'd had huge abdominal surgery, the last thing you'd want is somebody to be tipping you over every couple of hours, you know, and that's when I think our, we obviously see things..(6:6,1-6) I think you should use, your your um, initiative, I suppose a bit more, because you've been there 6 to 8 hours and you know how your patient's been going and you can sort of assess them and I think, get to know your patient a lot better than the people who come around and sort of do their rounds couple, you know, twice a day, (<i>Mm</i>) 'cause you're there, you see the changes and you see what happens when you turn them, and how it affects them, (<i>Mm</i>) sort of even just their heart rate and those sorts of things, you know, where they start breathing up a bit more and those sorts of things and, (<i>Mm</i>) I think, you know, when the physio's there if that causes them lots of discomfort and things, (6:6,15-26) I think um, at times they don't really, um, take into account that you've been there all the time, like I think that they should actually try and discuss with you how the patient's been going, 'cause, (<i>Mm</i>) you know, they just come along and say, "Well we'd better stop the, you know, the sedation or stop the analgesia or decrease it or something." You say, and then if you could, if they would just listen to you a bit more I think, (<i>Mm</i>) 'cause you've been there all day and you know how your patient is and (<i>and why</i>) and (<i>why you've got them to that state at that time</i>) to that point, time, yeah. (<i>Yeah, what's happened just before</i>) Yeah, exactly, so I think um, (<i>Yeah</i>) I think as nurses we're not often, sort of given enough credit for (<i>Mm</i>) being able to ascertain how uncomfortable your patient is or how they're too comfortable or whether they're getting too much pain relief or not enough.(6:6,33-7,10) Taylor I haven't been working long (<i>Yeah, yeah</i>) enough to know (<i>Yeah</i>) more so the levels to to give, if you know what I mean? Like (<i>Yeah</i>) I'd probably think, "Oh well, the doctors ordered that, I (<i>Oh yeah</i>) I shouldn't question that (9:10,29-33) doctors don't unders'.. they're not there doing, seeing the patient all the time and understand it. (<i>Yeah</i>) I I mean I know the patient you're talking about now, I I saw him when he (<i>Mm</i>) really did grimace when you turned him (<i>Mm</i>) and it was obvious, you know, he'd be (THE NURSE PULLS A FACE) (<i>Yeah</i>) and red face, and and um, yeah that is hard that is hard. (9:11,21-27) they don't see the procedures going on and (<i>Yeah</i>) The eight hours of the day that they're not there. (<i>Yeah</i>)</p>
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	<p>Yeah, I haven't, um, I know I know that situation, but I haven't really come across anything else, <i>(No)</i> and I like, I thought you meant like if if they're doctors have written up a level and you don't think that level is holding that patient, <i>(Oh right yeah)</i> but, I probably, I don't think I'm experienced enough to question, I should probably, but <i>(Mm)</i> to question how much that pain relief. <i>(9:12,1-9)</i></p>
<p>Final event</p>	<p>Patrick I think its a guess combined with, um, compassion combined with the fear <i>(5:23,21-22)</i> <i>(I wonder how we cope with all this torture that we do, but that's another study. (Um) It's all for a reason, that's why.)</i> Yeah. I think its its that's why I think its sort of you justify it through that. <i>(Yeah, the reason's pretty important.)</i> Mm mm <i>(5:25,28-26,3)</i> Toni I think at times you do tend to think, "Well, you know obviously they're in pain so I'll give them this." Whereas you don't really know, <i>(Yeah)</i> and its hard for you to know, yeah, its really, its sort of catch 22, if you don't give them something, they probably in pain, but if you do, whether they need it or not is another thing. <i>(6:13,29-34)</i> Rhea All I know what to do, and I can't say its a hundred percent right <i>(8:6,24-25)</i> its a very difficult thing to to actually do. <i>(Yeah)</i> Um, who knows what's right and who knows what's wrong. <i>(8:30,21-23)</i> I hope we're doing our best <i>(8:30,27)</i></p>

Appendix X**The original poem - *expressing a poem***

My first arrangement of the metaphorical ideas from nurses' transcripts, as described in sub-section 4.2.3.2 of the thesis, and the version for which I received positive feedback as described in sub-section 5.3.3 of the thesis.

Sometimes we look the other way
 nothing stands out
 we don't pick up on it
 it slips into the background.
 Sometimes our eyes are opened
 we see the whole picture.

They're leaping about the bed
 climbing out of bed
 going berserk
 screaming tachycardia
 throwing their guts up
 fighting
 gasping for breath
 as stiff as a book
 living torture
 nagging pain.

We put ourselves in their shoes
 because we see them coming along
 down the lane
 and we want to help them along
 but it's a fine line
 getting them to the peak
 getting to the edge
 but not over the cliff
 verging over the top
 coming back down a bit
 topping them up
 happy little medium
 not pushing them over the edge
 catch 22.

Sliced open abdomen
 pumping analgesia and sedation
 don't pussy foot
 don't dangle a piece of cake
 cover their pain
 knock off their memory
 combat
 hit and miss
 hit it right
 a bit under
 way off
 spaced out
 bombed out
 losing blood pressure
 make them into a contortionist.

Liver's shot
 encephalopic
 pull out
 don't let them linger

Appendix Y

Authentic words - revisiting the poem

I changed the poem to use the nurses' exact metaphorical words from the transcriptions rather than metaphorical ideas and referenced the actual location of the nurses' metaphors within the transcripts as described in sub-section 4.2.3.2 of the thesis.

look the other way (1:13,5)
ignoring it (5:1,34)
you couldn't pick up (4:4,4)
it slips into the background. (5:7, 2-3)
locked into this automatic pilot (5:9,15-16)
just palm it off onto someone else (9:6,9)

your eyes opened (8:14,16-17)
look at their condition as a whole picture
(1:8,1-2)
put yourself there (4:5,29)

they're leaping around in the bed (1:7,15)
climbing out of the bed (1:5,5-6)
going berserk (3:5,18)
blood pressure sky high (5:8,29)
screaming tachycardia (2:8,34)
trying to wrench their guts up (4:14,21)
fighting (8:22,25)
gasping for breath (9:14,24)
as stiff as a book (7:3,4)
living torture (8:9, 2-3)

put yourself in their shoes (4:8,6)
help them along (4:4,13)
can't find that fine line (8:14,3)
get them to a peak (4:9,33)
overstep that line (4:6,30)
overboard (4:9,28)
over the cliff (4:6,30)
get to the edge (4:6,32)
verging over the top (4:9,34)
come back down a little bit (4:9,35)
top them up again (4:9,20)
happy little medium (4:6,3)
catch 22. (4:15,2)

abdomen is right open (5:7,27)
just pumping pain relief and analgesia
(9:8,15)
none of this dangling a piece of cake
(4:20,16-17)
combat (5:7,19)
hit and miss (8:7,12)
hit it right (8:7,18)
covers your pain (10:3,19)
a bit under (1:6,3)
knock off your memory (10:8,14)
way off (8:7,23)
spaced out (4:8,3)
too bombed out (6:4,10)
losing blood pressure (1:7, 33-34)
make them into a contortionist. (4:7,8)

liver's shot (4:19,29)
encephalopic (1:6,3)
deteriorating (9:15,1)
a rotting mess (9:20,1-2)
pulled out (8:21,16-17)
not gonna let this pain, you know, linger
(3:7,27)

Appendix Z

Summary of Interview one - *summarising the conversation*

An example of one of the analytical tools I used, as described in sub-section 4.2.1.2 of the thesis.

Critically ill patients all experience pain and discomfort, however, those who are incapable of purposive actions need nurses to see the cues, have adequate theoretical knowledge, imagine themselves to be in the positions those patients are, and convince the doctors of their observations so that they can give the necessary care (stop the pain). However, nurses need experience to do this, it can only partially be taught, yet even experienced nurses are not totally confident in this aspect of nursing, because they are aware of individual uniqueness of each patient, cues to evaluate their care are minimal, and doctors do not always agree with the nurses' assessment of the situation.

The pain chart used in the unit is inadequate and not properly filled out by nurses and leads to uncertainty about the goal of analgesia. Sometimes doctors give unclear or conflicting orders. This nurse aims for the patient to "appear to be almost pain free", however, this may take more than an hour to assess. Adjusting the analgesia depends on physiological parameters, nursing procedures, size of patient, ventilation, contraindications, mental status, level of consciousness, rapport with patient. Other than analgesia, this nurse paces nursing procedures to promote patient comfort.

This nurse has learnt this aspect of nursing through watching other nurses and obtaining their advice, trial and error (which is safe in ICU where patients are monitored and ventilated), and formal teaching during the ICU course. This nurse thinks more education would improve care, but concedes this skill comes through experience. Incidences of patients remembering events that occurred when they were unconscious reinforces to this nurse that unconscious patients can experience, but it would be a good thing if the patients didn't remember.

References

- Agar, M. (1986). *Speaking of Ethnography*. Beverley Hills: Sage.
- Agar, M., & Hobbs, J., R. (1982). Interpreting discourse: coherence and the analysis of ethnographic interviews. *Discourse Processes*, 5, 1-32.
- Agar, M., & Hobbs, J., R. (1983). Natural plans: using AI planning in the analysis of ethnographic interviews. *Ethos*, 11(1/2), 33-48.
- Aguilera, D. C. (1990). Problem solving approach to crisis intervention. In D. C. Aguilera (Ed.), *Crisis Intervention: Theory and Methodology* (pp. 60-75). St Louis: The C.V. Mosby Company.
- Ahlers, S. J., van Gulik, L., van der Veen, A. M., van Dongan, H. P. A., Bruins, P., Belister, S. V., et al. (2008). Comparison of different pain scoring systems in critically ill patients in a general ICU. *Critical Care*, 12, 1-8.
- al Absi, M., & Rokke, P. D. (1991). Can anxiety help us tolerate pain? *Pain*, 46(1), 43-51.
- Allen, D., Benner, P., & Diekelmann, N. L. (1986). Three paradigms for nursing research: Methodological implications. In P. L. Chinn (Ed.), *Nursing research methodology and implementation* (pp. 23-37). Rockville: Aspen.
- Almerud, S., Alapack, R. J., Fridlund, B., & Ekebergh, M. (2008). Caught in an artificial split: A phenomenological study of being a caregiver in the technologically intense environment. *Intensive and Critical Care Nursing*, 24, 130-136.
- Alpert, H. B., Goldman, L. D., Kilroy, C. M., & Pike, A. W. (1992). 7 Gryzmish: Toward an understanding of collaboration. *Nursing Clinics of North America*, 27(1), 47-59.
- Altice, N. F., & Jamison, G. B. (1989). Interventions to facilitate pain management in myocardial infarction. *Journal of Cardiovascular Nursing*, 3(4), 49-56.
- Alt-White, A. C., Charns, M., & Strayer, R. (1983). Personal organizational and managerial factors related to nurse-physician collaboration. *Nursing Administration Quarterly*, 8, 8-18.
- Anderson-Nathe, B. (2008). Contextualizing Not-Knowing: Terminology and the role of professional identity. *Child & Youth Services*, 30(1/2), 11-25.
- Aristotle. (2004). *The Poetics* (I. Bywater, Trans.). USA: Kessinger Publishing LLC.
- Armstrong, I. (1993). *Victorian Poetry: Poetry, Poetics and Politics*. London: Routledge.
- Arndt, M. J. (1992). Caring as everydayness. *Journal of Holistic Nursing*, 10(4), 285-293.
- Aroskar, M. A. (1985). Ethical relationships between nurses and physicians: goals and realities - a nursing perspective. In A. H. Bishop & J. R. J. Scudder (Eds.), *Caring curing coping: nurse physician patient relationships* (pp. 44-61). Alabama: The university of Alabama Press.
- Arroyo-Novoa, C. M., Figueroa-Ramos, M. I., Puntillo, K. A., Stanik-Hutt, J., Thompson, C., White, C., et al. (2008). Pain related to tracheal suctioning in awake acutely and critically ill adults: A descriptive study. *Intensive and Critical Care Nursing*, 24, 20-27.
- Asbury, A. J. (1985). Patients memories and reactions to Intensive care. *Care of the Critically Ill*, 1(2), 12-13.
- Ashcroft, R. E., Dawson, A., Draper, H., & McMillian, J. R. (2007). *Principles of Health Ethics*. Chichester: John Wiley & Sons Ltd.
- Ashley, J. (1976). *Hospitals, paternalism and the role of the nurse*. New York: Teachers College Press.
- Ashley, J. (1980). Power in a structured mysogyny. *Advances in nursing science*, 2(3), 3-14.

- Ashworth, P. (1987). Communicating with patients and relatives in the intensive care unit. In W. Bridge & J. L. Macleod-Clark (Eds.), *Communication in Nursing Care*. London: HM&M.
- Atkinson, R. F. (1978). *Knowledge and Explanation in History: An Introduction to the Philosophy of History*. New York: Cornell University Press.
- Azoulay, E., Pochard, F., Chevret, S., Arich, C., Brivet, F., Brun, F., et al. (2003). Family participation in care to the critically ill: opinions of families and staff. *Intensive Care Medicine*, 29, 1498-1504.
- Babrow, A. S., Hines, S. C., & Kasch, C. R. (2000). Managing uncertainty in illness explanation: An application of problematic integration theory. In B. Whaley (Ed.), *Explaining illness: Research, theory, and strategies* (pp. 41-67). Hillsdale NJ: Erlbaum.
- Baer, E., Davitz, J. R., & Lieb, R. (1970). Inferences of physical pain and psychological distress in relation to verbal and nonverbal patient communication. *Nursing Research*, 19, 388.
- Baggs, J. G., Phelps, C. E., & Johnson, J. E. (1992). The association between interdisciplinary collaboration and patient outcomes in a medical intensive care unit. *Heart and Lung: Journal of Critical Care*, 21(1), 18-24.
- Baggs, J. G., & Schmitt, M. H. (1988). Collaboration between nurses and physicians. *IMAGE: Journal of Nursing Scholarship*, 20(3), 145-149.
- Bagley, C. S., Falinski, E., & Garnizo, N. (1982). Pain management: a pilot project. *Cancer Nursing*, 5, 191-199.
- Bailey, P. H. (1996). Assuring quality in narrative analysis. *Western Journal of Nursing Research*, 18(2), 186-194.
- Bailey, P. H., & Tilley, S. (2002). Storytelling and the interpretation of meaning in qualitative research. *Journal of advanced nursing*, 38, 574-583.
- Baker, C., Wuest, J., & Stern, P. N. (1992). Method slurring; the grounded theory/phenomenology example. *Journal of advanced nursing*, 17(11), 1355-1360.
- Ballard, K. S. (1981). Identification of environmental stressors for patients in a surgical intensive care unit. *Issues in Mental Health Nursing*, 3, 89-108.
- Ballard, N., Robley, L., Barrett, D., Fraser, D., & Mendoza, I. (2006). Patient's recollections of therapeutic paralysis in the intensive care unit. *American Journal of Critical Care*, 15, 86-94.
- Banks, S. A. (1992). Once upon a time: interpretation in literature and medicine. *Literature and Medicine*, 1(1), 24-28.
- Banning, M. (2007). A review of clinical decision making: models and current research. *Journal of Clinical Nursing*, 17, 187-195.
- Barnard, A. (2002). Philosophy of technology and nursing. *Nursing Philosophy*, 3, 15-26.
- Barrie-Shevlin, P. (1987). Maintaining sensory balance for critically ill patient. *Nursing*, 16, 597-601.
- Barthes, R. (1977). *Image, Music, Text*. New York: Hill and Wang.
- Bartky, S. (1990). Toward a Phenomenology of Feminist Consciousness. In *Femininity and Domination* (pp. 11-21). New York: Routledge.
- Basford, L., & Oliver, S. (2003). *Theory and Practice of Nursing: An Integrated Approach to Caring Practice* (2nd ed.). Cheltenham: Nelson Thornes.
- Bauman, R. (1986). *Story, performance and event*. Cambridge: Cambridge University Press.
- Beach, W. A., & Japp, P. (1981). Storifying as time-travelling: The knowledgeable use of temporally structured discourse. In J. C. Kelly (Ed.), *A philosophy of communication: Exploration for a systematic model* (pp. 867-888). London: Centre for the study of communications and culture.

- Beach, W. A., & Japp, P. (1983). Storifying as time-travelling: The knowledgeable use of temporally structured discourse. In R. N. Bostrom (Ed.), *Communication Yearbook* (Vol. 7, pp. 867-888). Beverley Hills: Sage Publications.
- Beecher, H. (1956). Relationship of significance of wound to pain experienced. *Journal of the American Medical Association*, 161, 17.
- Beiner, R. (1982). *Hannah Arendt: Lectures on Kant's political philosophy*. Chicago: Chicago University Press.
- Belenky, M., Clinchy, B. M., Goldberger, N. R., & Tartule, J. M. (1986). *Women's ways of knowing: The development of self, voice and mind*. New York: Basic Books.
- Bell, S. E. (1988). Becoming a political woman: the reconstruction and interpretation of experience through stories. In A. D. Todd & S. Fisher (Eds.), *Gender and Discourse: The Power of Talk* (pp. 97-125). Norwood NJ: Ablex.
- Bell, S. E. (1999). Narratives and lives: Women's health politics and the diagnosis of cancer for DES daughters. *Narrative Inquiry*, 9(2), 347-389.
- Benner, P. (1984). *From novice to expert*. Menlo Park, California: Addison-Wesley Publishing Company.
- Benner, P. (1985). Quality of life: a phenomenological perspective on explanation, prediction, and understanding in nursing science. *Advances in nursing science*, 8(1), 1-14.
- Benner, P. (1991). The role of experience, narrative, and community in skilled ethical comportment. *Advances in nursing science*, 14(2), 1-21.
- Benner, P. (2000). The wisdom of our practice. *American Journal of Nursing*, 100(10), 99-101,103,105.
- Benner, P., & Tanner, C. (1987). Clinical judgment: how expert nurses use intuition. *American Journal of Nursing*, 23-31.
- Benner, P., Tanner, C. A., & Chelsa, C., A. (1996). *Expertise in nursing practice: caring, clinical judgement and ethics*. New York: Springer publishing company.
- Benner, P., & Wrubel, J. (1989). *The Primacy of Caring: Stress and Coping in Health and Illness*. Menlo Park, California: Addison-Wesley Publishing Company.
- Bennett, G. (1986). Narrative as Expository Discourse. *The Journal of American Folklore*, 99(394), 415-434.
- Bergbom-Engberg, I., & Haljamae, H. (1989). Assessment of patients' experience of discomforts during respiratory therapy. *Intensive Care Medicine*, 17, 1068-1072.
- Bergbom-Engberg, I., & Haljamae, H. (1993). The communication process with ventilator patients in the ICU as perceived by the nursing staff. *Intensive and Critical Care Nursing*, 9(1), 40-47.
- Bergbom-Engberg, I., & Haljamae, H. (1988). A retrospective study of patients' recall of respirator treatment (2): Nursing care factors and feelings of security/insecurity. *Intensive Care Nursing*, 4, 95-101.
- Berker, M., & Hughes, B. (1990). Using a tool for pain assessment. *Nursing Times*, 86(24), 50-52.
- Bernauer, E. A., & Yeager, M. P. (1993). Optimal pain control on the intensive care unit. *International Anesthesiology Clinics*, 31(2), 201-221.
- Bernay-Roman, A. (1994). High-touch for a high tech world. *Revolution; The Journal of Nurse Empowerment*, 44-47.
- Bevis, E. M., & Clayton, G. (1988). Needed: A new curriculum development design. *Nurse Educator*, 13(4), 14-18.
- Beyerman, K. (1982). Flawed perceptions about pain. *American Journal of Nursing*, 82(2), 302-304.
- Biley, F. (1992). Using music in hospital settings. *Nursing Standard*, 6(35), 37-39.
- Bines, H., & Watson, D. (1992). *Developing professional education*. Buckingham: SRHE & Open University Press.

- Boba, A., Cincotti, J. J., Peazza, T. E., & Landmesser, C. M. (1959). The effects of apnea, endotracheal suction, and oxygen insufflation, alone and in combination, upon arterial saturation in anesthetized patients. *Journal of Laboratory Clinical Medicine*, 53, 680-685.
- Bond, A. E., Mandleco, B., & Warnick, M. L. (2004). At the heart of nursing: Stories reflect the professional values in AACN's *Essentials* document. *Nurse Educator*, 29, 84-88.
- Bond, M. (1988). *Stress and Self-Awareness: A Guide for Nurses*. Oxford: Heinemann.
- Bondestam, E., Hovgren, K., Gaston Johansson, F., Jern, S., Herlitz, J., & Holmberg, S. (1987). Pain assessment by patients and nurses in early phase of acute myocardial infarction. *Journal of advanced nursing*, 12(6), 677-682.
- Borkan, J., Shvartzman, P., Reis, S., & Morris, A., G. (1993). Stories from the sealed rooms: Patient interviews during the Gulf War. *Family Practice*, 10(2), 188-192.
- Borkan, J. M., Quirk, M., & Sullivan, M. (1991). Finding meaning after the fall: Injury narratives from elderly hip fracture patients. *Social Science and Medicine*, 33(8), 947-957.
- Botes, A. (2000). A comparison between the ethics of justice and the ethics of care. *Journal of advanced nursing*, 32(5), 1071-1075.
- Bourdieu, P. (1980/1990). *The logic of practice*. Stanford CA: Stanford University Press.
- Boykin, A., & Schoenhofer, S. O. (1991). Story as link between nursing practice, ontology, epistemology. *IMAGE: Journal of Nursing Scholarship*, 23(4), 245-248.
- Brashers, D. E. (2001). Communication and Uncertainty Management. *Journal of Communication*, 51(3), 477-497.
- Brazil, D., Coulthard, M., & Johns, C. (1980). *Discourse intonation and language teaching*. London: Longman.
- Brooks, P. (1984). *Reading for the Plot. Design and Intention in Narrative*. New York: Vintage Books.
- Brown, L. (1986). The experience of care: patient perspectives. *Topics in Clinical Nursing*, 8(2), 56-62.
- Bruner, E. M. (1984). Introduction: The opening up of anthropology. In E. M. Bruner (Ed.), *Text, play and story* (pp. 1-16). Prospect Heights Ill.: Waveland Press.
- Bruner, E. M. (1986). Ethnography as Narrative. In V. W. Turner & E. M. Bruner (Eds.), *The Anthropology of Experience* (pp. 139-155). Urbana: University of Illinois Press.
- Bruner, J. (1986). *Actual minds, possible worlds*. Cambridge: Harvard University Press.
- Buckelew, S. P., Shutty, M. S. J., Hewett, J., Landon, T., Morrow, K., & Frank, R. G. (1990). Health locus of control, gender differences and adjustment to persistent pain. *Pain*, 42(3), 287-294.
- Buckenham, J. E., & McGrath, G. (1983). *The Social Reality of Nursing*. Sydney: ADIS Health Science Press.
- Bucknall, T. K., & Thomas, S. A. (1997). Nurses' reflections on problems associated with decision-making in critical care areas. *Journal of advanced nursing*, 25, 229-237.
- Burns, N., & Grove, S. (2004). *The Practice of Nursing Research: Conduct, Critique, and Utilization* (5th ed.). Philadelphia: W B Saunders.
- Butler, D., & Moseley, D. L. (2003). *Explain Pain*. Adelaide SA: Noigroup publications.
- Butts, J. B., & Rich, K. (2005). *Nursing Ethics: across the curriculum and into practice*. Mississauga Canada: Jones and Bartlett Publishers Canada.
- Cade, C. (2008). Clinical Tools for the assessment of pain in sedated critically ill patients. *Nursing in Critical Care*, 13(6), 288-297.
- Cairns, K. V. (1994). A narrative study of qualitative data on sexual assault, coercion and harassment. *Canadian Journal of Counselling*, 28(3), 193-205.

- Calne, S. (1994). Dehumanisation in intensive care. *Nursing Times*, 90(17), 31-33.
- Camp, L. D. (1988). A comparison of nurses' recorded assessments of pain with perceptions of pain as described by cancer patients. *Cancer Nursing*, 11(4), 237-243.
- Camp, L. D., & O'Sullivan, P. S. (1987). Comparison of medical, surgical and oncology patients' descriptions of pain and nurses documentation of pain assessments. *Journal of advanced nursing*, 12(5), 593-598.
- Campbell, C. (1984). *Nursing Diagnosis and Intervention in Nursing Practice*. New York: Wiley.
- Campbell, M. L., & Field, B. E. (1991). Management of the patient with do not resuscitate status: compassion and cost containment. *Heart and Lung: Journal of Critical Care*, 20(4), 345-348.
- Campbell-Heider, N., & Pollock, D. (1987). Barriers to physician-nurse collegiality: An anthropological perspective. *Social Science and Medicine*, 25, 421-425.
- Camp-Sorrell, D., & O'Sullivan, P. (1991). Effects of continuing education: pain assessment and documentation. *Cancer Nursing*, 14(1), 49-54.
- Canzian, S., & Dabbs, J. (2008). *A standardized order form for the provision of comfort care during withdrawal of invasive physiologic support*. Paper presented at the CANN Scientific Sessions.
- Carr, D. (1991). *Time, Narrative and History*. Bloomington: Indiana University Press.
- Cassell, E. J. (1985). *The Healer's Art*. Cambridge MA: MIT Press.
- Catalano, J. T. (2008). Professional Ethics. In R. Kearney-Nunnery (Ed.), *Advancing your career; concepts of professional nursing* (4th ed., pp. 250-267). Portland OR: F. A. Davis.
- Caygill, H. (1995). *A Kant Dictionary*. Oxford: Blackwell Publishing.
- Cazden, C., & Hymes, D. (1978). Narrative thinking and storytelling rights: a folklorist's clue to a critique of education. *Keystone Folklore*, 22(1-2), 21-36.
- Chambers, W., & Price, G. (1967). Influence of nurse upon effects of analgesic administered. *Nursing Research*, 16, 228-233.
- Chanques, G., Jaber, S., Barbotte, E., Violet, S., Sebbane, M., Perrigault, P., et al. (2006). Impact of systematic evaluation of pain and agitation in an intensive care unit. *Critical Care Medicine*, 34(6), 1691-1699.
- Chapman, G. E. (1988). Text, talk and discourse in a therapeutic community. *The International Journal of Therapeutic Communities*, 9(2), 75-87.
- Chapman, H. (1996). Why do nurses not make use of a solid research base? *Nursing Times*, 92(3), 38-39.
- Charles-Edwards, A. (1983). *The Nursing Care of the Dying Patient*. Beaconsfield: Beaconsfield Publishers Ltd.
- Chatman, S. (1981). Critical response: reply to Barbara Herrnstein Smith. *Critical Inquiry*, 7, 802-809.
- Cheever, K. H. (1999). Reducing the effects of acute pain in critically ill patients. *Dimensions of Critical Care Nursing*, 18(3), 14-23.
- Chen, Y.-c. (1990). Psychological and social support systems in intensive and critical care. *Intensive Care Nursing*, 6, 59-66.
- Chenitz, W. C., & Swanson, J. M. (1986). *From Practice to Grounded Theory*. Menlo Park: Addison Wesley.
- Chew, S. L. (1986). Psychological reactions of intensive care patients. *Care of the Critically Ill*, 2(2), 62-65.
- Chiarella, M. (2002). *The legal and professional status of nursing*. Edinburgh: Churchill Livingstone.
- Chinn, P. L., & Jacobs, M. K. (1986). *Theory and Nursing: A Systematic Approach*. St Louis: Mosby.
- Choiniere, M., Melzack, R., Girard, N., Rondeau, J., & Paquin, M. J. (1990). Comparisons between patients' and nurses' assessment of pain and medication efficacy in severe burn injuries. *Pain*, 40, 143-152.

- Christman, N. J., Kirchhoff, K. T., & Oakley, M. G. (1992). Concrete objective information. In G. B. Bulacheck & J. C. McCloskey (Eds.), *Nursing Interventions: Essential Nursing Treatments* (pp. 140-150). Philadelphia: Saunders.
- Christoph, S. B. (1991). The problem of pain in the critically ill patient. *Critical Care Nursing Clinics of North America*, 3(1), 11-16.
- Chulder, & Dong. (1983). The assessment of pain by cerebral evoked potentials. *Pain*, 16, 221-240.
- Churchill, L. R., & Churchill, S. W. (1992). Storytelling in medical arenas: the art of self determination. *Literature and Medicine*, 1(1), 74-81.
- Chyun, D. (1989). Patient's perceptions of stressors in intensive and coronary care units. *Focus on Critical Care*, 16(3), 206-211.
- Cirocco, M. (2007). How reflective practice improves nurses' critical thinking ability. *Gastroenterology Nursing*, 30(6), 405-413.
- Clark, S., Fontaine, D. K., & Simpson, T. (1994). Recognition, assessment and treatment of anxiety in the critical care setting. *Critical Care Nurse*, 2-14.
- Clarke, J. (1985). Coping with Guillain Barre syndrome. (A personal experience). *Intensive Care Nursing*, 1(1), 13-18.
- Clayton, G. M., Murray, J. P., Horner, S. D., & Greene, P. E. (1991). Connecting: A catalyst for caring. In P. L. Chinn (Ed.), *Anthology on Caring* (pp. 155-168). New York: National League for Nursing Press.
- Cody, W. K., & Kenney, J. W. (2006). *Philosophical and Theoretical Perspectives for Advanced Nursing Practice*. Sudbury MA: Jones and Bartlett Publishers.
- Coeling, H. V. E., & Wilcox, J. R. (1991). Professional recognition and high-quality patient care through collaboration: two sides of the same coin. *Focus on Critical Care*, 18(3), 230-237.
- Cohen, F. (1980). Post-surgical pain relief: patients' status and nurses' medication choice. *Pain*, 9, 265-274.
- Collins, L. (2007). Seeking balance in relationships with patients: Understanding 'overinvolvement'. *British Journal of Neuroscience Nursing*, 3(3), 117-122.
- Connelly, F. M., & Clandinin, D. J. (1990). Stories of experience and narrative inquiry. *Educational Researcher*, 19(5), 2-14.
- Coombs, M., & Ersser, S. J. (2004). Medical hegemony in decision-making - a barrier to interdisciplinary working in intensive care? *Journal of advanced nursing*, 46(3), 245-252.
- Council, A. N. a. M. (1993). Code of Ethics for Nurses in Australia. Dickson ACT: Australian Nursing and Midwifery Council.
- Council, A. N. a. M. (2002). Code of Ethics for Nurses in Australia. Dickson ACT: Australian Nursing and Midwifery Council.
- Council, A. N. a. M. (2008). Code of Ethics for Nurses in Australia. Dickson ACT: Australian Nursing and Midwifery Council.
- Council, N. H. a. M. R. (1989). Management of severe pain. Canberra: Australian Publishing Service.
- Coyer, F. M., Wheeler, M. K., Wetzig, S. M., & Couchman, B. A. (2007). Nursing care of the mechanically ventilated patient: What does the evidence say? *Intensive and Critical Care Nursing*, 23, 71-80.
- Craig, K. D. (1989). Emotional aspects of pain. In P. D. Wall & R. Melzack (Eds.), *Textbook of Pain*. Edinburgh: Churchill Livingstone.
- Cranford, R. E. (1988). The persistent vegetative state: the medical reality (Getting the facts straight). *Hastings Centre Report*, 18(1), 27.
- Cranley, L., Doran, D., Tourangeau, A., Kushniruk, A., & Nagle, L. (2009). Nurses' uncertainty in decision-making: a literature review. *Worldviews on Evidence-Based Nursing*, 6(1), 3-15.

- Crippen, D., & Ermakov, S. (1992). Stress, agitation, and brain failure in critical care medicine. *Critical Care Nursing Quarterly*, 15(2), 52-74.
- Crisp, J. (1987). *Analysis of the Nurse/Doctor Relationship*. Macquarie University.
- Crites, S. (1986). Storytime: Recollecting the past and projecting the future. In T. R. Sarbin (Ed.), *The Storied Nature of Human Conduct* (pp. 152-173). New York: Praeger.
- Crotty, M. (1994). Overheads from the Phenomenology Workshop. In P. G. N. S. a. UTS (Ed.).
- Culler, J. (1981). *The pursuit of signs, semiotics, literature, deconstruction*. Cornell, UP: Ithaca.
- Daffurn, K., Bishop, G. F., Hillman, K. M., & Bauman, A. (1994). Problems following discharge after intensive care. *Intensive and Critical Care Nursing*, 10, 244-251.
- Darbyshire, P. (1987). Doctors and nurses: The burden of history. *Nursing Times*, 32-34.
- Davis, P. S. (1988). Changing nursing practice for more effective control of post operative pain through a staff initiated educational programme. *Nurse Education Today*, 8(6), 325-331.
- Davitz, L. L., & Davitz, J. R. (1980). *Nurses' Response to Patients' Suffering*. New York: Springer Publishing Company.
- Davitz, L. L., Davitz, J. R., & Higuchi, Y. (1977). Cross-cultural inferences of physical pain and psychological distress. *Nursing Times*, 73, 556-558.
- Dayton, N. (1992). The old 'doctor-nurse game' - today's professional nurses decide to quit playing. *Tennessee Nurse*, 55(3), 11.
- De Giogio, C. M., & Lew, M. F. (1991). Consciousness, Coma, and the Vegetative State: Physical Basis and Definitional Character. *Issues in Law and Medicine*, 6(4), 361-371.
- Dealtry, R. (1992). *Nursing assessment of acute pain*. Paper presented at the Pain busters: One day course on acute pain management., John Lowenthal Auditorium, Westmead Hospital.
- d'Entre ves, M. P. (1994). *The Political Philosophy of Hannah Arendt*. New York: Routledge.
- Denzin, N. K. (1986). Interpretive interactionism and the use of life stories. *Reva? Int Sociol*, 44, 331-337.
- Denzin, N. K. (1987). *The alcoholic self*. Newbury Park, CA: Sage.
- Descartes, R. (1664/1972). *Treatise of Man* (T. S. Hall, Trans.). Cambridge Mass: Harvard University Press.
- Diers, D. (2004). *Speaking of nursing: narratives of practice, research, policy and the profession*. Mississauga, Ontario Canada: Jones and Bartlett Publishers Canada.
- Diers, D., Schnmidt, R., McBride, M., & Davis, B. (1972). The effects of nursing interaction on patients in pain. *Nursing Research*, 21(5), 419-428.
- Doering, L. V. (1993). The effect of positioning on hemodynamics and gas exchange in the critically ill: A review. *American Journal of Critical Care*, 2(3), 208-216.
- Dolphin, N. W. (1983). Neuroanatomy and neurophysiology of pain: nursing implications. *International Journal of Nursing Studies*, 20(4), 255-263.
- Donahue, P. (1989). *Nursing: The finest art*. St Louis: CV Mosby Co.
- Donovan, M., Dillon, P., & McGuire, L. (1987). Incidence and characteristics of pain in a sample of medical-surgical inpatients. *Pain*, 30, 69-78.
- Doran, D., Myopoulos, J., Kushniruk, A., Nagle, L., Strauss, S., Sidani, S., et al. (2007). Evidence in the palm of your hand: Development of an outcome-focussed knowledge translation intervention. *Worldviews on Evidence-Based Nursing*, 4, 1-9.
- Dorland. (1988). *Dorland's Illustrated Medical Dictionary*.

- Dracup, K. (1988). Are critical care units hazardous to health? *Applied Nursing Research*, 1(1), 14-21.
- Draper, P. (1996). What are the implications of integration for nursing research and nursing education? *Nurse Education Today*, 16, 239-240.
- Drew, N. (1986). Exclusion and confirmation: a phenomenology of patients' experiences with caregivers. *IMAGE: Journal of Nursing Scholarship*, 18(2), 39-43.
- Dreyfus, H. L., & Dreyfus, S. E. (1986). *Mind over machine, the power of human intuition and expertise in the era of the computer*. New York: The Free Press.
- Dudley, S., & Holm, K. (1984). Assessment of the pain experience in relation to select nurse characteristics. *Pain*, 18(2), 179-186.
- Duffy, A. (2007). A concept analysis of reflective practice: determining its value to nurses. *British Journal of Nursing*, 16(22), 1400-1407.
- Dunn, C. (1990). Improving intensive care. *Nursing Times*, 86(12), 32-34.
- Dyer, I. (1995a). Preventing the ITU syndrome or how not to torture an ITU patient! Part 1. *Intensive and Critical Care Nursing*, 11, 130-139.
- Dyer, I. (1995b). Preventing the ITU syndrome or how not to torture an ITU patient! Part 2. *Intensive and Critical Care Nursing*, 11, 223-232.
- Dzurec, L. C. (1989). The necessity for and evolution of multiple paradigms for nursing research: A poststructuralist perspective. *Advances in nursing science*, 11(4), 60-77.
- Earl, J. (1979). Controlled ventilation - a horror story (or take me off the ventilator so I can breathe). *Respiratory Care*, 24, 193.
- Ehrenreich, B., & English, D. (1973). *Witches, midwives and nurses: A history of women healers*. Old Westbry, NY: The Feminist Press.
- Eich, E., Reeves, J. L., & Jaegar, B. (1985). Memory for pain: relation between past and present pain intensity. *Pain*, 23, 375-379.
- Eich, E., Reeves, J. L., Jaegar, B., & Graff-Radford, S. B. (1985). Memory for pain: relation between past and present pain intensity. *Pain*, 23, 375-389.
- Eich, E., Reeves, J. L., & Katz, R. L. (1985). Anesthesia, Amnesia, and the Memory/Awareness Distinction. *Anesthesia and Analgesia*, 64, 1143-1148.
- Ekman, P., & Friesen, W. V. (1978). *Facial action coding system: A technique for the measurement of facial movement*. Palo Alto: Consulting Psychologists Press.
- Eland, J. M. (1986). The assessment of pain in children. In *Integrated approach to management of pain*. Warren Grant Magnusen Clinical Centre, U.S.A.: National Institutes of Health.
- England, D. A. (1986). *Collaboration in Nursing*. Rockville, MD: Aspen.
- Erskine, A., Morley, S., & Pearce, S. (1990). Memory for pain: A review. *Pain*, 42(255-265).
- Eubanks, P. (1991). Quality improvement key to changing nurse-MD relations. *Hospitals*, 65(8), 26-30.
- Evans, D. (1990). Problems in the decision making process: A review. *Intensive Care Nursing*, 6, 179-184.
- Fagerberg, I. (2004). Registered Nurses' work experiences: personal accounts integrated with professional identity. *Journal of advanced nursing*, 46(3), 284-291.
- Fagerstrom, L. (2006). The dialectic tension between 'being' and 'not being' a good nurse. *Nursing Ethics*, 13(6), 622-632.
- Fagin, C. M. (1992). Collaboration between nurses and physicians: No longer a choice. *Academic Medicine*, 67, 295-303.
- Fanslow, J. (1987). Compassionate nursing care: is it a lost art? *Journal of Practical Nursing*, 37(2), 40-43.
- Faries, J. E., Mills, D. S., Goldsmith, K. W., Phillips, K. D., & Orr, J. (1991). Systematic pain records and their impact on pain control: a pilot study. *Cancer Nursing*, 14(6), 306-313.

- Fawcett, J. (1980). A declaration of nursing independence: the relation of theory and research to nursing practice. *The Journal of Nursing Administration*, 10, 36-39.
- Ferraro, K. J., & Johnson, J. M. (1983). How women experience battering: the process of victimization. *Social Problems*, 30(3), 325-339.
- Ferrell, B. R., Eberts, M. T., McCaffery, M., & Grant, M. (1991). Clinical decision making and pain. *Cancer Nursing*, 14(6), 289-297.
- Ferrell, B. R., & Leek, C. J. (1991). Pain. In J. L. Creasia & B. Parker (Eds.), *Conceptual Foundations of Professional Nursing Practice* (pp. 345-362). St Louis: Mosby Year Book.
- Ferrell, B. R., McCaffery, M., & Grant, M. (1991). Clinical decision making and pain. *Cancer Nursing*, 14(6), 289-297.
- Field, T. (2000). *Touch Therapy*. London: Churchill Livingstone.
- Finder, S. G., & Bliton, M. J. (2001). Interplays of reflection and text: telling the case. *American Journal of Bioethics*, 1(1), 56-57.
- Folkman, S. (1984). Personal control and stress and coping processes: A theoretical analysis. *Journal of Personality and Social Psychology*, 46(4), 839-852.
- Fonteyn, M. E. (1991). Implications of clinical reasoning studies for critical care nursing. *Focus on Critical Care*, 18(4), 322-327.
- Forrest, D. (1989). The experience of caring. *Journal of advanced nursing*, 14, 815-823.
- Forster, E. M. (1927). *Aspects of the Novel*. London: Edward Arnold & Co.
- Foucault, M. (1976). *The Archeology of Knowledge*. New York: Harper & Row.
- Fox, L. S. (1982). Pain management in the terminally ill cancer patient: an investigation of nurses' attitudes, knowledge and clinical practice. *Military Medicine*, 147(6), 455-460.
- French, B. (2006). Uncertainty and information need in nursing. *Nurse Education Today*, 26, 245-252.
- Freshwater-Turner, D. A., Boots, R. J., Bowman, R. N., Healy, H. G., & Klestov, A. C. (2007). Difficult decisions in the intensive care unit: an illustrative case. *Anaesthesia and Intensive Care*, 35(5), 748-759.
- Friese, R. S. (2008). Sleep and recovery from critical illness and injury: a review of theory, current practice, and future directions. *Critical Care Medicine*, 36(3), 697-705.
- Funk, S. G., Tornquist, E. M., & Champagne, M. T. (1995). Barriers and facilitators of research utilization: an integrated review. *Nursing Clinics of North America*, 30(3), 395-407.
- Gaarger, J. (2007). *Sophie's World* (P. Moller, Trans.). New York: Farrar, Straus and Giroux.
- Gadamer, G. (1975). *Truth and Method*. London: Sheed & Ward.
- Gadamer, H. G. (1975). *Truth and Method*. London: Duckworths.
- Gadow, S. (1980). Existential advocacy: philosophical foundation of nursing. In S. F. Spicker & S. Gadow (Eds.), *Nursing: Images and Ideals* (pp. 79-111). New York: Springer Publishing Company.
- Gadow, S. (1989). Clinical subjectivity: advocacy with silent patients. *Nursing Clinics of North America*, 24(2), 535-541.
- Gadow, S. (1995). Response to "The contrary ideals of individualism and nursing value of care". *Scholarly Inquiry for Nursing Practice: An International Journal*, 9(3), 241-244.
- Gaut, D. A. (1986). Evaluating caring competencies in nursing practice. *Topics in Clinical Nursing*, 8(2), 77-83.
- Gee, J. P. (1985). The narrativization of experience in the oral style. *Journal of Education*, 167(1), 9-35.
- Gee, J. P. (1986). Units in the production of narrative discourse. *Discourse Processes*, 9, 391-422.

- Gee, J. P. (1989a). Dracula, the vampire Lestat, and TESOL. *TESOL Quarterly*, 22(2), 201-225.
- Gee, J. P. (1989b). "Literariness", Formalism, and Sense Making: The line and stanza structure of human thought. *Journal of Education*, 171(1), 61-74.
- Gee, J. P. (1989c). The narrativization of experience in the oral style. *Journal of Education*, 171(1), 75-96.
- Gee, J. P. (1989d). Orality and Literacy: From the savage mind to ways with words. *Journal of Education*, 171(1), 39-60.
- Gee, J. P. (1989e). Two style of narrative construction and their linguistic and educational implications. *Journal of Education*, 171(1), 97-115.
- Gee, J. P. (1991). A linguistic approach to narrative. *Journal of Narrative and Life History*, 1(1), 15-39.
- Gee, J. P., & Grosjean, F. (1984). Empirical evidence for narrative structure. *Cognitive Science*, 8, 59-85.
- Gee, J. P., & Kegl, J. A. (1983). Narrative/story structure, pausing, and American sign language. *Discourse Processes*, 6, 243-257.
- Gelinas, C., Fillion, L., Puntillo, K. A., Viens, C., & Fortier, M. (2006). Validation of the critical-care pain observation tool in adult patients. *American Journal of Critical Care*, 15(4), 420-427.
- Gelinas, C., Harel, F., & Fillion, L. (2009). Sensitivity and specificity of the Critical-Care Pain Observation Tool (CPOT) for the detection of pain in intubated ICU adult patients. *Journal of Pain and Symptom Management*, 37, 58-67.
- Gelinas, C., & Johnston, C. (2007). Pain assessment in the critically ill ventilated adult: validation of the Critical Care Pain Observation Tool and physiologic indicators. *Clinical Journal of Pain*, 23, 497-505.
- Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge MA: Harvard University Press.
- Girard, K. G., & Raffin, T. A. (1985). The chronically ill: To save or let die? *Respiratory Care*, 30(5), 339-347.
- Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine.
- Glide, S. (1994). Maintaining sensory balance. *Nursing Times*, 90(17), 33-34.
- Good, B. J., & Good, M.-J. D. V. (1994). In the subjunctive mode: Epilepsy narratives in Turkey. *Social Science and Medicine*, 38(6), 835-842.
- Good, M.-J. D. V., Munakata, T., Kobayashi, Y., Mattingly, C., & Good, B. J. (1994). Oncology and narrative time. *Social Science and Medicine*, 38(6), 855-862.
- Goodnow, M. (1935). *The Technic of Nursing*. Philadelphia: W.B. Saunders.
- Gordon, D. (2005). *Nursing against the odds*. New York: Cornell Press.
- Gordon, D., & Alexander, G. (2005). The education of story lovers: do computers undermine narrative sensibility? *Curriculum Inquiry*, 35(2), 133-159.
- Graffam, S. (1990). Pain content in the curriculum: a survey. *Nurse Educator*, 15(1), 20-23.
- Gramling, K. L. (2004). A Narrative Study of Nursing Art in Critical Care. *Journal of Holistic Nursing*, 22(4), 379-398.
- Green, A. (1992). How nurses can ensure the sounds patients hear have a positive rather than negative effect upon recovery and quality of life. *Intensive and Critical Care Nursing*, 8, 245-248.
- Green, L. (1994). Touch and visualisation to facilitate a therapeutic relationship in an intensive care unit - a personal experience. *Intensive and Critical Care Nursing*, 10, 51-57.
- Greenberg, N., Carr, J., & Summers, C. H. (2002). Causes and consequence of stress. *Integrative and Comparative Biology*, 42(3), 508-516.
- Gregory, D., & Longman, A. (1992). Mothers' suffering: Sons who die of AIDS. *Qualitative Health Research*, 2(3), 334-357.

- Greimas, A. J., Ricoeur, P., Perron, P., & Collins, F. (1989). On Narrativity. *New Literary History*, 20(3), 551-562.
- Gries, M. L., & Fernsler, J. (1988). Patient perceptions of the mechanical ventilation experience. *Focus on Critical Care*, 15, 52-59.
- Griffin, A. P. (1983). A philosophical analysis of caring in nursing. *Journal of advanced nursing*, 8, 289-295.
- Grobe, S., Drew, J., & Fonteyn, M. (1991). A descriptive analysis of experienced nurses' clinical reasoning during a planning task. *Research in Nursing and Health*, 14(4), 305-314.
- Guba, E. G. (1981). Criteria for Assessing the Trustworthiness of Naturalistic Inquiries. *ECTJ.*, 29(2), 75-91.
- Guba, E. G., & Lincoln, Y. S. (1989). Paradigms and Methodologies. In *Fourth Generation Evaluation* (pp. 156-183). Newbury Park: Sage Publications.
- Gumperz, J. J. (1982). *Discourse Strategies*. Cambridge: Cambridge University Press.
- Guyton-Simmons, J., & Mattoon, M. (1991). Analysis of Strategies in the Management of Coronary Patients' Pain. *Dimensions of Critical Care Nursing*, 10(1), 21-27.
- Haberkern, C. M., Tyler, D. C., & Krane, E. J. (1991). Postoperative pain management in children. *Mt Sinai Journal of Medicine*, 58(3), 247-256.
- Hagland, M., R. (1995). Nurse-patient communication in intensive care: a low priority? *Intensive and Critical Care Nursing*, 11, 111-115.
- Halfens, R., Evers, G., & Abu-Saad, H. (1990). Determinants of pain assessment by nurses. *International Journal of Nursing Studies*, 27(1), 43-49.
- Hall, J. M., Stevens, P. E., & Meleis, A. I. (1992). Developing the construct of role integration: A narrative analysis of women clerical workers' daily lives. *Research in Nursing and Health*, 15, 447-457.
- Halliwell, R. (1992). *Patient controlled analgesia*. Paper presented at the Pain Busters: One day course on acute pain management, Westmead Hospital.
- Hall-Lord, M. L., Larsson, G., & Bostrom, I. (1994). Elderly patients' experiences of pain and distress in intensive care: a grounded theory study. *Intensive Care Nursing*, 10, 133-141.
- Halm, M. A., & Alpen, M. A. (1993). The impact of technology on patients and families. *Advances in nursing science*, 28(2), 433-457.
- Hamilton, J. (1989). Comfort and the hospitalised chronically ill. *Journal of Gerontological Nursing*, 15(14), 28-33.
- Hamilton, S. (1991). Collaborative practice is necessary in ICU. *Nursing Management*, 96J-96L.
- Hand, D. (1991). Facts and fantasies. *Nursing Standard*, 5(15), 17-19.
- Hanselmann, M., & Tanner, C. (2008). Taboos and conflicts in decision making: Sacred values, decision difficulties and emotions. *Judgment and Decision Making*, 3(1), 51-63.
- Hardingham, L. (1994). Ethics in the workplace: silence and collaboration in nursing. *AARN*, 50(7), 12-13.
- Hardy, B. (1968). Towards a poetics of fiction: an approach through narrative. *Novel*, 2, 5.
- Harma, M. (1993). Individual differences in tolerance to shiftwork: a review. *Ergonomics*, 36(1-3), 101-109.
- Harre, R. (1985). The language game of self-ascriptions: a note. In K. J. Gergen & K. E. Davis (Eds.), *The social construction of the person*. New York: Springer-Verlag.
- Harrison, A. (1991). Assessing patients' pain: identifying reasons for error. *Journal of advanced nursing*, 16(9), 1018-1025.
- Harrison, M., & Cotanch, P. H. (1987). Pain: advances and issues in critical care. *Nursing Clinics of North America*, 22(3), 691-696.

- Harrower, M. (1972). *The therapy of poetry*. Springfield IL: Charles C Thomas.
- Hartwig, D. (1991). *Dorothea Orem: Self-Care Deficit Theory (Notes on Nursing Theories)*. Newbury Park: Sage Publications.
- Hawkes, T. (1972). *Metaphor*. London: Methuen & Co. Ltd.
- Hay, D., & Oken, D. (1972). The Psychological Stresses of Intensive Care Unit Nursing. *Psychosomatic Medicine*, 34(2), 109-119.
- Heath, A. (1992). Imagery: helping ICU patients control pain and anxiety. *Dimensions of Critical Care Nursing*, 11(1), 57-62.
- Heath, J. V. (1989). What the patients say. *Intensive Care Nursing*, 5, 101-108.
- Hedberg, B., & Larsson, U. S. (2003). Observations, confirmations and strategies - useful tools in decision-making process for nurses in practice? *Journal of Clinical Nursing*, 12, 215-222.
- Hegel, G. W. F. (1977). *Phenomenology of Spirit* (A. V. Miller, Trans.). Oxford: Clarendon Press.
- Heland, M. (2006). Fruitful or futile: Intensive care nurses' experiences and perceptions of medical futility. *Australian Critical Care*, 19(1), 25-31.
- Helms, J. E., & Barone, C. P. (2008). Physiology and treatment of pain. *Critical Care Nurse*, 28(6), 38-49.
- Henschel, E. O. (1977). The Guillain-Barre Syndrome: A personal experience. *Anesthesiology*, 47, 228-231.
- Herlitz, J., Richter, A., Hjalmarson, A., & Holmberg, S. (1986). Variability of chest pain in suspected acute myocardial infarction according to subjective assessment and requirement of narcotic analgesia. *International Journal of Cardiology*, 13(1), 9-26.
- Herr, K., Coyne, P. J., Manworren, R., McCaffery, M., Merkel, S., Pelosi-Kelly, J., et al. (2006). Pain assessment in the nonverbal patient: position statement with clinical practice recommendations. *Pain Management Nursing*, 7(2), 44-52.
- Herron, J., & Reason, P. (1997). A participatory inquiry paradigm. *Qualitative Inquiry*, 3(3), 274-294.
- Higgs, J., & Titchen, A. (2001). Rethinking the practice-knowledge interface in an uncertain world: a model for practice development. *British Journal of Occupational Therapy*, 64(11), 526-533.
- Hill, C. F. (1993). Is massage beneficial to critically ill patients in intensive care units? A critical review. *Intensive and Critical Care Nursing*, 9, 116-121.
- Hinshaw, A. S., Chance, H. C., & Atwood, J. (1981). Research in practice: a process of collaboration and negotiation. *The Journal of Nursing Administration*, 11, 33-38.
- Hinshaw, A. S., & Smeltzer, C. H. (1987). Research challenges and programs for practice settings. *JONA*, 17(7,8), 20-26.
- Hirsch, A. R. (2001). Aromatherapy for pain relief: A practical guide for clinicians. In R. Weiner, S (Ed.), *Pain Management* (6th ed., pp. 1025-1038): American Academy of Pain Management.
- Hodgson, L. (1991). Why do we need sleep? Relating theory to nursing practice. *Journal of advanced nursing*, 16, 1503-1510.
- Holm, K., Cohen, F., Dudas, S., Medema, P., G, & Allen, B. L. (1989). Effect of personal pain experience on pain assessment. *IMAGE: Journal of Nursing Scholarship*, 21(2), 72-75.
- Holmes, C. (1992, 1-2 July). *The politics of phenomenological research in nursing*. Paper presented at the Nursing Research: Scholarship for practice, Deakin University, Geelong.
- Holmes, R. (1986). The knower and the known. *Sociological Forum*, 1(4), 610-631.
- Hosking, J., & Welchew, E. (1985). *Postoperative pain - understanding its nature and how to treat it*. London: Faber & Faber.

- Hov, R., Hedelin, B., & Athlin, E. (2007). Being an intensive care nurse related to the question of withholding or withdrawing curative treatment. *Journal of Clinical Nursing, 16*, 203-211.
- Hoyt, K. S., & Sparger, G. (1984). Pain assessment by ED nurses. *Journal of Emergency Nursing, 10*(6), 306-312.
- Hudacek, S. S. (2008). Dimensions of caring: A qualitative analysis of nurses' stories. *Journal of Nursing Education, 47*(3), 124-129.
- Hudak, C. M. (1986). *Critical care nursing: a holistic approach* (4th edition ed.). Philadelphia: J.B. Lippincott Company.
- Hunt, L. M. (1994). Practicing oncology in provincial Mexico: A narrative analysis. *Social Science and Medicine, 38*(6), 843-853.
- Hunter, M., Phillips, C., & Rachman, S. (1979). Memory for pain. *Pain, 6*, 35-46.
- Hymes, D. (1964). *Language in Culture & Society: A Reader in Linguistics & Anthropology*. New York: Harper & Row.
- Hymes, D. (1982). Narrative form as a "grammar" of experience: Native Americans and a glimpse of English. *Journal of Education, 164*, 121-142.
- Ihde, D. (1980). *Hermeneutic Phenomenology: The Philosophy of Paul Ricoeur*. Evanston, Illinois: Northwestern University Press.
- Infante, M. C., & Mooney, N. E. (1987). Interactive aspects of pain assessment. *Orthopaedic Nursing, 6*(1), 31-34.
- Irwin, R. S., & Rippe, J., M. (2008). *Irwin and Rippe's intensive care medicine*. Philadelphia: Lippincott Williams & Wilkins.
- Jackson, M. (2002). *Pain: The fifth vital sign*. New York: Crown Publishers.
- Jacox, A. K. (1979). Assessing pain. *American Journal of Nursing, 79*(5), 895-900.
- Jantzen, D. (2007). Reframing professional development for first-line nurses. *Nursing Inquiry, 15*(1), 21-29.
- Jaros, J. A. (1991). The concept of pain. *Critical Care Nursing Clinics of North America, 3*(1), 1-10.
- Jefferson, G. (1978a). Explanations of Transcript Notation. In J. Schenkein (Ed.), *Studies in the Organization of Conversation Interaction*. New York: Academic Press.
- Jefferson, G. (1978b). Sequential aspects of storytelling in conversation. In J. Schenkein (Ed.), *Studies in the organization of conversational interaction* (pp. 219-248). New York: Academic Press.
- Jelinek, M. (1992). The clinical and the randomised control trial. In J. Daly, I. McDonald & E. Willis (Eds.), *Researching Health Care* (pp. 76-90). London: Routledge.
- Jenks, J. M. (1993). The pattern of personal knowing in nurse clinical decision making. *Journal of Nursing Education, 32*(9), 399-405.
- Jennett, B., & Plum, F. (1972). Persistent vegetative state after brain damage. A syndrome in search of a name. *The Lancet, 1*, 734.
- Jennett, B., & Teasdale, G. (1981). *Management of head injuries*: FA Davis Company.
- Jenny, J., & Logan, J. (1992). Knowing the patient: one aspect of clinical knowledge. *IMAGE: Journal of Nursing Scholarship, 24*(4), 254-258.
- Joachim, G. (1983). Step by step massage techniques. *The Canadian Nurse, 4*, 32-35.
- Johanson, L. R., Magnani, B., Chan, V., & Ferrante, F. M. (1989). Modifiers of patient-controlled analgesia efficacy. 1. Locus of control. *Pain, 39*(1), 17-22.
- Johnson, J. E. (1972). Effects of structuring patients' expectations on their reactions to threatening events. *Nursing Research, 21*, 499-504.
- Johnson, M. M., & Sexton, D. L. (1990). Distress during mechanical ventilation: patients' perceptions. *Critical Care Nurse, 10*, 48-57.
- Johnson, N. S., & Mandler, J. M. (1980). A tale of two structures: underlying and surface forms in stories. *Poetics, 9*, 51-86.
- Johnston, L., & Fineout-Overholt, E. (2005). Teaching EBP: Getting from zero to one. Moving from recognizing and admitting uncertainties to asking searchable, answerable answers. *Worldviews on Evidence-Based Nursing, 2*, 98-102.

- Jones, C. (1979). Glasgow coma scale. *American Journal of Nursing*, 79(2), 1551-1553.
- Jones, J., Hoggart, B., Withey, J., & Donaghue, K. (1979). What the patients say: a study of reactions to an intensive care unit. *Intensive Care Medicine*, 5, 89-92.
- Jones, S. (1994). Graduate Research Seminar. In M. H. Faculty of Nursing (Ed.). UTS Lindfield Campus.
- Kabes, A. M., Graves, J. K., & Norris, J. (2009). Further validation of the Nonverbal Pain Scale in intensive care patients. *Critical Care Nurse*, 29(1), 59-66.
- Kahn, D. L., & Steeves, R. H. (1988). Caring and practice: construction of the nurses' world. *Scholarly Inquiry for Nursing Practice: An International Journal*, 2(3), 201-216.
- Kaiser, K. S. (1992). Assessment and management of pain in the critically ill trauma patient. *Critical Care Nursing Quarterly*, 15, 14-34.
- Kaliterna, L., Vidacek, S., Radosevic-Vidacek, B., & Prizmic, Z. (1993). The reliability and stability of various individual differences and tolerances to shiftwork measures. *Ergonomics*, 36(1-3), 183-189.
- Kangas, S., Warren, N. A., & Byrne, M. M. (1998). Metaphor: The language of nursing researchers. *Nursing Research*, 47, 190-193.
- Kant, I. (2004). *The Critique of Judgement*. Whitefish: Kessinger Publishing Company.
- Kassirer, J., & Kopelman, R. (1986). Treat - or keep testing? *Hospital Practice*, 21, 41-56.
- Katz, J., & Melzack, R. (1990). Pain 'memories' in phantom limbs: review and clinical observation. *Pain*, 43(3), 319-336.
- Kavanagh, K. H. (1988). The cost of caring: Nursing on a psychiatric intensive care unit. *Human Organization*, 47(3), 242-251.
- Keddy, B., Gillis, M. J., Jacobites, P., & al., e. (1986). The doctor/nurse relationship: An historical perspective. *Journal of advanced nursing*, 11, 745.
- Keddy, B., Jones-Gillis, M., Jacobs, P., Burton, H., & Rogers, M. (1986). The doctor-nurse relationship: An historical perspective. *Journal of advanced nursing*, 11, 745-753.
- Kelleher, S. (2006). Providing patient-centred care in an intensive care unit. *Nursing Standard*, 21(13), 35-40.
- Kelly, M. P., & May, D. (1982). Good and bad patients: a review of the literature and a theoretical critique. *Journal of advanced nursing*, 7, 147-156.
- Kemp, T. P. (1988). Toward a narrative ethics: a bridge between ethics and the narrative reflections of Ricoeur. *Philosophy and Social Criticism*, 14, 179-201.
- Kent, G. (1985). Memory of Dental Pain. *Pain*, 21, 187-194.
- Kido, L. M. (1991). Sleep deprivation and intensive care unit psychosis. *Emphasis: Nursing*, 4(1), 23-33.
- Kilmann, R. H., & Thomas, K. W. (1977). Developing a forced-choice measure of conflict-handling behaviour: The "MODE" instrument. *Educational and Psychological Measurement*, 37, 309-325.
- Kim, E. Y. H. (1994). Interpersonal relationships between the nurses and the doctors, professional performance and quality of care. *Philippine Journal of Nursing*, 64(1), 17-18.
- Kim, H. S. (2000). *The nature of theoretical thinking in nursing* (2nd ed.). New York: Springer Publishing.
- King, C. D. R. M. L., & Lee, J. L. (1994). Perceptions of collaborative practice between navy nurses and physicians in the ICU setting. *American Journal of Critical Care*, 3(5), 331-336.
- King, C. D. R. M. L., Lee, J. L., & Henneman, E. (1993). A collaborative practice model for critical care. *American Journal of Critical Care*, 2(6), 444-449.

- Klein, D. B. (1970). *A history of scientific psychology*. London: Routledge & Kegan Paul.
- Knaus, W., Draper, E. A., Wagner, D. P., & Zimmerman, J. E. (1986). An evaluation of outcomes from intensive care in major medical centres. *Annals of internal medicine*, *104*, 410-418.
- Kockelmans, J. (1975). Towards an interpretive of hermeneutic social science. *Graduate Faculty Philosophy Journal: New School of Social Research*, *5*(1), 73-96.
- Kolcaba, K. Y. (1991). A taxonomic structure for the concept of comfort. *IMAGE: Journal of Nursing Scholarship*, *23*(4), 237-240.
- Kolcaba, K. Y. (1992). The concept of comfort in an environmental framework. *Journal of Gerontological Nursing*, 33-38.
- Kolcaba, K. Y. (1992). Holistic comfort: operationalizing the construct as a nurse-sensitive outcome. *Advances in nursing science*, *15*(1), 1-10.
- Kolcaba, K. Y. (2003). *Comfort theory and practice*. New York: Springer Publishing.
- Kolcaba, K. Y. (2006). Comfort. In J. J. Fitzpatrick & W. Meredith (Eds.), *Encyclopedia of Nursing Research* (2nd ed., pp. 92-94). New York: Springer Publishing Company, Inc.
- Kolcaba, K. Y., & Kolcaba, R. J. (1991). An analysis of the concept of comfort. *Journal of advanced nursing*, *16*, 1301-1310.
- Kooker, B. M., Shoultz, J., & Codier, E. E. (2007). Identifying emotional intelligence in professional nursing practice. *Journal of Professional Nursing*, *23*(1), 30-36.
- Krysl, M. (1991). Sometimes a person needs a story more than food to stay alive. In R. Schaperow (Ed.), *Curriculum Revolution: Community Building and Activism* (pp. 29-40). New York: National League for Nursing Press.
- Kuhn, T. S. (1970). *The structure of scientific revolutions*. Chicago: University of Chicago Press.
- Kundrik, S. (2007). Preconceptions: A concept analysis for nursing. *Nursing Forum*, *42*(3), 109-122.
- Labov, W. (1972). *Language in the Inner City*. Philadelphia: University of Philadelphia Press.
- Labov, W. (1982). Speech action and reactions in personal narrative. In D. Tannen (Ed.), *Analysing Discourse: Text and Talk* (pp. 219-247). Washington D.C.: Georgetown University Press.
- Labov, W., & Fanshel, D. (1977). *Therapeutic Discourse: Psychotherapy as Conversation*. New York: Academic Press.
- Labov, W., & Waletzky, J. (1967). Narrative analysis: Oral versions of personal experience. In J. Helms (Ed.), *Essays on the verbal and visual arts: Proceedings of the 1966 Annual Spring Meeting of the American Ethnological Society* (pp. 12-44). Seattle: University of Washington Press.
- Lackey, N. R. (1992). Qualitative research methodologies: application, part II. *Journal of Post Anesthesia Nursing*, *7*(2), 119-128.
- Ladanyi, S., & Elliott, D. (2007). Experiences of uncertainty for relatives in ICU: A review of a qualitative Danish study. *Australian Critical Care*, *20*(4), 146-148.
- Lakoff, G., & Johnson, M. (1980). *Metaphors we live by*. Chicago: University of Chicago Press.
- Lamb, G. S., & Napadano, R. J. (1984). Physician-nurse practitioner interaction patterns in primary care practices. *American Journal of Public Health*, *74*, 26-29.
- Lander, J. (1990). Fallacies and phobias about addiction and pain. *British Journal of Addiction*, *85*(6), 803-809.
- Langellier, K. M. (1989). Personal Narrative: Perspectives on theory and research. *Text and Performance Quarterly*, *9*(4), 243-276.

- Langellier, K. M., & Peterson, E. E. (2004). *Storytelling in daily life: performing narrative*. Philadelphia: Temple University Press.
- Larson, D. G. (1987). Internal stressors in nursing: helper secrets. *Journal of Psychosocial Nursing*, 23(4), 20-26.
- Larson, P. J. (1987). Comparison of cancer patients' and professional nurses' perceptions of important nurse caring behaviours. *Heart and Lung: Journal of Critical Care*, 16(2), 187-193.
- Lau, R., Chan, S., & Chan, S. (1995). The stressors of nurses in the intensive care unit in Hong Kong. *Hong Kong Nursing Journal*(69), 17-24.
- Lawler, J. (1991). *Behind the Screens: Nursing, Somology, and the Problem of the Body*. Melbourne: Churchill Livingstone.
- Lawler, J. (1991, 15-17 July 1991). *What you see is not always what you get: seeing feeling and researching in nursing. Invited Keynote Address*. Paper presented at the Nursing Research: Pro-active vs Reactive, First International Conference of the Centre for Nursing Research Inc. in collaboration with the Royal College of Nursing, St Peter's College, Adelaide.
- Lazarus, R. S. (1991). *Emotion and Adaptation*. New York: Oxford University Press.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer Publishing.
- Leach, S. (1992). *Feminist research processes: reflections of a study*. Paper presented at the Nursing research: scholarship for practice, Geelong.
- Leathart, A. (1994). Communication and socialisation (2): perceptions of neophyte ITU nurses. *Intensive and Critical Care Nursing*, 10, 142-154.
- Leathart, A. J. (1994). Communication and socialisation (1): an exploratory study and explanation for nurse-patient communication in an ITU. *Intensive and Critical Care Nursing*, 10, 93-104.
- Leininger, M. (1986). Care facilitation and resistance factors in the culture of nursing. *Topics in Clinical Nursing*, 8(2), 1-12.
- Lempert, L. B. (1994). A narrative analysis of abuse: connecting the personal, the rhetorical, and the structural. *Journal of Contemporary Ethnography*, 22(4), 411-441.
- Leners, D. W. (1993). Nursing intuition: The deep connection. In D. A. Gaut (Ed.), *A global agenda for caring* (pp. 223-240). New York: National League for Nursing.
- Leonard, V. W. (1989). A Heideggerian phenomenologic perspective on the concept of the person. *Advances in nursing science*, 11(4), 40-55.
- LeResche, L., & Dworkin, S. F. (1988). Facial expressions of pain and emotions in chronic TMD patients. *Pain*(35), 71-78.
- Leske, J. S. (1991). Internal psychometric properties of the Critical Care Family Needs Inventory. *Heart and Lung: Journal of Critical Care*, 20(5), 236-244.
- Levin, R. F., Malloy, G. B., & Hyman, R. B. (1987). Nursing management of postoperative pain: use of relaxation techniques with female cholecystectomy patients. *Journal of advanced nursing*, 12(4), 463-472.
- Levine, F. M., & De Simone, L. L. (1991). The effects of experimenter gender on pain report in male and female subjects. *Pain*, 44(1), 69-72.
- Levine, M. E. (1973). Adaptation and assessment: a rationale for nursing intervention. In M. E. Hardy (Ed.), *Theoretical foundations for nursing*. New York: Irvington.
- Li, D., Puntillo, K. A., & Miaskowski, C. (2008). A review of objective pain measures for use with critical care adult patients unable to self-report. *The Journal of Pain*, 9(1), 2-10.
- Liaschenko, J., & Fisher, A. (1999). Theorizing the knowledge that nurses use in the conduct of their work. *Scholarly Inquiry for Nursing Practice: An International Journal*, 13(1), 29-41.

- Linde, C. (1986). Private stories in public discourse. *Poetics*, 15, 183-202.
- Lindquist, R., Robert, R. C., & Treat, D. (1990). A clinical practice journal club: Bridging the gap between research and practice. *Focus on Critical Care*, 17(5), 402-406.
- Lipshitz, R., & Strauss, O. (1997). Coping with uncertainty: A naturalistic decision-making analysis. *Organizational behaviour and human decision processes*, 69(2), 149-163.
- Lipton, J. A. (1986). Cultural aspects of pain assessment. In *Integrated approach to management of pain*. Warren Grant Magnusen Clinical Centre, U.S.A.: National Institutes of Health.
- Lisson, E. L. (1987). Ethical issues related to pain control. *Nursing Clinics of North America*, 22, 649-659.
- Loeser, J. D. (1982). Concepts of Pain. In M. Stanton-Hicks & R. Boaz (Eds.), *Chronic Low Back Pain*. New York: Raven Press.
- Loper, K. A., Butler, S., Nessly, M., & al., e. (1989). Paralyzed with pain: the need for education. *Pain*, 37, 315-316.
- Lovell, M. C. (1981). Silent but perfect "partners": Medicine'd use and abuse of women. *Advances in nursing science*, 3, 25-40.
- Luckenbill Brett, J. L. (1989). Organizational integrative mechanisms and adoption of innovation by nurses. *Nursing Research*, 38(2), 105-110.
- Lumby, J. (1991). Threads of an emerging discipline: praxis, reflection, rhetoric and research. In G. Gray & R. Pratt (Eds.), *Towards a Discipline of Nursing* (pp. 461-483). Melbourne: Churchill Livingstone.
- Lumby, J. (1995). *Stories of Care: Nursing Narratives*. Sydney: Universtiy of Technology.
- Lyotard, J.-F. (1984). *The Postmodern Condition: A Report on Knowledge* (G. Bennington & B. Massumi, Trans.). Manchester: Manchester University.
- MacGuire, J. M. (1990). Putting nursing research findings into practice: research utilization as an aspect of the management of change. *Journal of advanced nursing*, 15, 614-620.
- MacIntyre, A. (1981). *After Virtue*. Notre Dame: University of Notre Dame Press.
- MacKay, R. C., Matsuno, K., & Mulligan, J. (1991). Communication problems between doctors and nurses. *Quality Assurance in Health Care*, 3(1), 11-19.
- MacKellaig, J. A. (1986). A study of psychological effects of intensive care with particular emphasis on patients in isolation. *Intensive Care Nursing*, 2, 176-185.
- MacLeod, M. (1993). On knowing the patient: experiences of nurses undertaking care. In A. Radley (Ed.), *Worlds of illness: Biographical and cultural perspectives on health and disease* (pp. 179-197). London: Routledge.
- Maddi, S. R. (2002). The story of hardiness: Twenty years of theorizing, research and practice. *Consulting Psychology Journal*, 54, 173-185.
- Magarey, J. M., & McCutcheon, H. H. (2005). 'Fishing with the dead' - recall of memories from the ICU. *Intensive and Critical Care Nursing*, 21, 344-354.
- Mahan, K. T., & Strelecky, D. C. (1991). Recent concepts in understanding a child's pain. *Journal of the American Pediatric Association*, 81(5), 231-242.
- Mandler, J. M. (1984). *Stories, Scripts, and Scenes: Aspects of Schema Theory*. Hillsdale, New Jersey: Lawrence Erlbaum Associates.
- Manojlovich, M., Antonakas, C. L., & Ronis, D. L. (2009). Intensive Care Units, communication between nurses and physicians. *American Journal of Critical Care*, 18, 21-30.
- Marks, R. M., & Sacher, E. J. (1973). Undertreatment of medical inpatients with narcotic analgesia. *Annals of internal medicine*, 78(2), 173-181.
- Marsden, C. (1990). Ethics of the "doctor-nurse game". *Heart and Lung: Journal of Critical Care*, 19(4), 422-424.

- Martin, S. (1990). Nurses take in alternatives. *Here's Health*, 18-20.
- Maslow, A. (1943). A theory of human motivation. *Psychological Review*, 50(4), 370-396.
- Maslow, A. (1954). *Motivation and Personality*. New York: Harper & Row.
- Mason, D. J. (1981). An investigation of the influences of select factors on nurses' inferences of patient suffering. *International Journal of Nursing Studies*, 18(4), 251-259.
- Mateo, O. M., & Krenzischek, D. A. (1992). A pilot study to assess the relationship between behavioural manifestations and self-report of pain in post anesthesia care unit patients. *Journal of Postanesthesia Nursing*, 7(1), 15-20.
- Mather, L. E., & Phillips, G. D. (1986). Opioids and adjuvants in acute pain management. In M. Cousins & G. Phillips (Eds.), *Acute Pain Management* (pp. 77-78). Melbourne: Churchill Livingstone.
- Mauksch, H. O., & Campbell, J. D. (1987). The nursing presence examined by assessing joint practice (pp. 157-175): NLN Publications.
- Maxwell, T., & Pope, B. (2006). When it comes down to comfort: palliative care in the ICU. *Critical Care*, 36(2), 64cc61-64cc64.
- May, C. (1991). Affective neutrality and involvement in nurse-patient relationships: perceptions of appropriate behaviour among nurses in acute medical and surgical wards. *Journal of advanced nursing*, 16, 552-558.
- Mayeroff, M. (1971). *On Caring*. New York: Harper & Row.
- Mazza, N. (1996). Poetry therapy: A framework and synthesis of techniques for family social work. *Journal of Family Social Work*, 1(3), 3-18.
- McAllister, M., & Osborne, S. (2006). Teaching and learning practice development for change. *Journal of Continuing Education in Nursing*, 37(4), 154-159.
- McCabe, H. (2007). Nursing the patient in pain: rights and virtue. *Nursing Monograph*, 4-8.
- McCaffery, M. (1968). *Nursing practice theories related to cognition, bodily pain, and man- environment interactions*. Los Angeles: University of California.
- McCaffery, M. (1990). Nursing approaches to nonpharmacological pain control. *International Journal of Nursing Studies*, 27(1), 1-5.
- McCaffery, M., & Beebe, A. (1989). *Clinical manual for nursing practice*. St Louis: The C.V. Mosby Company.
- McCaffery, M., & Pasero, C. (1999). Assessment. Underlying complexities, misconceptions, and practical tool. In M. McCaffery & C. Pasero (Eds.), *Pain: clinical manual* (2nd ed., pp. 33-102). St Louis: Mosby.
- McGuire, D. B. (1984). The measurement of clinical pain. *Nursing Research*, 1984(33), 152-156.
- McIlveen, K. H., & Morse, J. (1995). The role of comfort in nursing care: 1900-1980. *Clinical Nursing Research*, 4(2), 127-148.
- McIntyre, A. (1985). *After Virtue. A Study in Moral Theory*. London: Duckworths.
- McMahan, E. M., Hoffman, K., & McGee, G. W. (1994). Physician-nurse relationships in clinical settings: a review and critique of the literature, 1966-1992. *Medical Care Research & Review*, 51(1), 83-112.
- McMahan, M. A., & Miller, P. (1978). Pain response: the influence of psycho-social-cultural factors. *Nursing Forum*, 17(1), 58-71.
- McMillan, S. C., Williams, F., A, Chatfield, R., & Camp, L. D. (1988). A validity and reliability study of two tools for assessing and managing cancer pain. *Oncology Nursing Forum*, 15(6), 735-741.
- McPherson, P. (1987). The quality of being expressed as doing. *The Australian Journal of Advanced Nursing*, 5(1), 38-42.
- McQuillen, M. P. (1991). Can people who are unconscious or in the "vegetative state" perceive pain? *Issues in Law and Medicine*, 6(4), 373-383.

- Mead, G. H. (1962). *Mind, self and society*. Chicago: University of Chicago Press.
- Mechanic, D., & Aiken, L. (1982). A cooperative agenda for medicine and nursing. *New England Journal of Medicine*, 307, 747-750.
- Meighan, S. (1991). Improving relations among RN's, MD's and CEO's. *Hospitals*, 64.
- Melosh, M. (1982). *The Physician's Hand*. Philadelphia: Temple University Press.
- Melzack, R. (1973). *The puzzle of pain*. Ringwood: Penguin Books.
- Melzack, R. (1984). Neuropsychological basis of pain measurement. In L. Kruger & J. C. Liebeskind (Eds.), *Advances in Pain Research and Therapy* (Vol. 6, pp. 323-339). New York: Raven Press.
- Melzack, R., & Torgenson, W. S. (1971). On the language of pain. *Anesthesiology*, 34(1), 50-59.
- Melzack, R., & Wall, P. D. (1965). Pain mechanisms: A new theory. *Science*, 150(3699), 971-979.
- Melzack, R., & Wall, P. D. (1967). Pain mechanisms: A new theory. *Science*, 150, 971-979.
- Menna-Barreto, L., Benedito-Silva, A. A., Moreno, C. R. C., Fischer, F. M., & Marques, N. (1993). Individual differences in night and continuously-rotating shiftwork: seeking anticipatory rather than compensatory strategy. *Ergonomics*, 36(1-3), 135-140.
- Merkel, S. (2002). Pain assessment in infants and young children: the finger span scale. *The American Journal of Nursing*, 102(11), 55-56.
- Merkel, S. I., Shayevitz, J. R., Voepel-Lewis, T., & Malviya, S. (1997). The FLACC: a behavioural scale for scoring postoperative pain in young children. *Pediatric Nursing*, 23, 293-297.
- Merleau-Ponty, M. (1962). *Phenomenology of Perception*. New York: Humanities Press.
- Merskey, H., & Spears, F. G. (1967). *Pain: Psychological and psychiatric aspects*. London: Bailliere, Tindall and Cassell.
- Mersky, H. (1979). Pain terms: A list with definitions and notes in usage. *Pain*, 6, 249-252.
- Messick, S. (1989). Validity. In R. L. Linn (Ed.), *Educational Measurement*. New York: Macmillan.
- Miller, B. F., & Keane, C. B. (1983). *Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health*. Philadelphia: W.B. Saunders Company.
- Mills, N., M. (1989). Pain behaviours in infants and toddlers. *Journal of Pain and Symptom Management*, 4(4), 184-190.
- Minden, P. (2005). The Importance of Words. *Holistic Nursing Practice*, 19(6), 267-271.
- Minichiello, V., Aroni, R., Timewell, E., & Alexander, L. (1990). *In-Depth Interviewing: Researching People*. Melbourne: Longman Cheshire.
- Mishler, E. G. (1986a). The analysis of interview-narratives. In T. R. Sarbin (Ed.), *Narrative psychology - the storied nature of human conduct* (pp. 233-253). New York: Praeger.
- Mishler, E. G. (1986b). *Research Interviewing: Context and Narrative*. Cambridge: Harvard University Press.
- Mishler, E. G. (1990). Validation in inquiry-guided research: The role of exemplars in narrative studies. *Harvard Educational Review*, 60(4), 415-442.
- Mitchell, P. H., Armstrong, S., Simpson, T., & Lentz, M. (1989). American Association of Critical Care Nurses Demonstration Project: Profile of excellence in critical care nursing. *Heart and Lung: Journal of Critical Care*, 18, 219-237.
- Mlynczak, B. (1989). Assessment and management of the trauma patient in pain. *Critical Care Nursing Clinics of North America*, 1(1), 55-65.
- Monroe, S. M. (2008). Modern approaches to conceptualizing and measuring human life stress. *Annual Review of Clinical Psychology*, 4, 33-52.

- Montgomery, C. L. (1992). The spiritual connection: nurses' perceptions of the experience of caring. In D. A. Gaut (Ed.), *The Presence of Caring in Nursing* (pp. 39-52). New York: National League for Nursing.
- Moore, T. (1989). Sensory deprivation in the ICU. *Nursing*, 3(36), 44-47.
- Morley, S. (1993). Vivid memory for everyday pains. *Pain*, 55(1), 55-62.
- Morse, J., Bottoroff, J., Anderson, G., O'Brien, B., & Solberg, S. (2006). Beyond Empathy: expanding expressions of caring. *Journal of advanced nursing*, 53, 75-87.
- Morse, J. M. (1983). An ethnoscientific analysis of comfort: a preliminary investigation. *Nursing Papers*, 15(1), 6-19.
- Morse, J. M. (1991). Negotiating commitment and involvement in the nurse-patient relationship. *Journal of advanced nursing*, 16, 455-468.
- Morse, J. M. (1992). Comfort: the refocusing of nursing care. *Clinical Nursing Research*, 1(1), 91-106.
- Morse, J. M., Anderson, G., Bottorff, J. L., Yonge, O., O'Brien, B., Solberg, S. M., et al. (1992). Exploring empathy: A conceptual fit for nursing practice? *IMAGE: Journal of Nursing Scholarship*, 24(4), 273-280.
- Morse, J. M., Bottorff, J., Anderson, G., O'Brien, B., & Solberg, S. (1992). Beyond empathy: expanding expressions of caring. *Journal of advanced nursing*, 17, 809-821.
- Morse, J. M., Bottorff, J. L., & Hutchinson, S. (1995). The paradox of comfort. *Nursing Research*, 44(1), 14-19.
- Morse, J. M., & Carter, B. J. (1995). Strategies of enduring and the suffering of loss: modes of comfort used by a resilient survivor. *Holistic Nursing Practice*, 9(3), 38-52.
- Morse, J. M., Solberg, S. M., Neander, W. L., Botorff, J. L., & Johnson, J. L. (1990). Concepts of caring and caring as a concept. *Advances in nursing science*, 13(1), 1-14.
- Moruzzi, N. C. (2001). *Speaking through the mask: Hannah Arendt and the politics of social identity*. New York: Cornell University Press.
- Moss, F. T., & Meyer, B. (1966). Effects of nursing interaction upon pain relief in patients. *Nursing Research*, 15, 303-306.
- Moss, M. T. (1995). Perioperative nursing in the managed care era: collaborative relationships in the OR. Part I - Obstacles. *Nursing Economics*, 13(4), 254-255.
- Muir, B. L. (1980). *Pathophysiology - an introduction to the mechanism of disease*. New York: John Wiley & Sons.
- Mumby, D. K. (1987). The political function of narrative in organizations. *Communication Monographs*, 54, 113-127.
- Munoz, S. J. (2008). Hepatic encephalopathy. *Medical Clinics of North America*, 92(4), 792-812.
- Munz, P. (1977). *The Shapes of Time*. Middletown: Wesleyan University Press.
- Murrell, D. (1992). *Pain in children*. Paper presented at the Pain Busters: On day course on acute pain management, Westmead Hospital.
- Mynchenberg, T. L., & Dungan, J., M. (1995). A relaxation protocol to reduce patient anxiety. *Dimensions of Critical Care Nursing*, 14(2), 78-85.
- Nelson, S. (1993, October 1993). *Pains/games: a Wittgensteinian analysis of language and taxonomies of pain*. Paper presented at the Shaping Nursing Theory and Practice, 2nd National Conference, Department of Nursing, La Trobe University.
- Nemni, S. R. (1988). *A psychophysical methodology for the development of measurement scales: the quantification of the qualities of cancer pain*. Unpublished Doctoral dissertation, Texas Christian University, Fort Worth, TX.

- Nightingale, F. (1859). *Notes on Nursing*. London: Harrison.
- Nugent, O., Glass, C. A., Krishnan, M. B., & Bingley, J. D. (1992). An investigation of the relationship between environmental factors and job satisfaction in intensive nursing, with particular reference to spinal trauma. *Paraplegia*, 30, 489-496.
- O'Connell, B. (2000). Enabling care: Working through obscurity and uncertainty - A basic social process used in select acute care settings. *Australian Journal of Advanced Nursing*, 34, 32-39.
- Odhner, M., Wegman, D., Freeland, N., Steinmetz, A., & Ingersoll, G. L. (2003). Assessing pain control in nonverbal critically ill adults. *Dimensions of Critical Care Nursing*, 22(6), 260-267.
- O'Gara, P. T. (1988). The haemodynamic consequences of pain and its management. *Journal of Intensive Care Medicine*(3), 3-5.
- Olsson, G., & Parker, G. (1987). A model approach to pain assessment. *Nursing*, 17(5), 52-58.
- O'Reilly, F. P., Penn, E. M., & DeMarras, K. B. (2001). *Educating Young Adolescent Girls*. Mahwah, New Jersey: Lawrence Erlbaum Associates.
- Orlando, I. (1961). *The Dynamic Nurse-Patient Relationship: Function, Process and Principles*. New York: Putman.
- O'Sullivan, R. J. (1991). A musical road to recovery: music in intensive care. *Intensive Care Nursing*, 7, 160-163.
- Paice, J. A., Mahon, S. M., & Faut-Callahan, M. (1991). Factors associated with adequate pain control in hospitalized postsurgical patients diagnosed with cancer. *Cancer Nursing*, 14(6), 298-305.
- Paley, J. (2006). Evidence and expertise. *Nursing Inquiry*, 13(2), 82-93.
- Parker, K. P. (1995). Promoting sleep and rest in critically ill patients. *Critical Care Nursing Clinics of North America*, 7(2), 337-349.
- Parker, R. S. (1990). Nurses' stories: The search for a relational ethic of care. *Advances in nursing science*, 13(1), 31-40.
- Pasero, C., & McCaffery, M. (2002). Pain in the critically ill. *The American Journal of Nursing*, 102(1), 59-60.
- Paterson, J., & Zderad, L. (1988). *Humanistic Nursing*. New York: National League for Nursing.
- Patton, M. J. (1990). *Qualitative Evaluation and Research Methods*. Newbury Park: Sage Publications.
- Payen, J. F., Bru, O., Bosson, J. L., Lagrasta, A., Novel, E., Deschaux, L., et al. (2001). Assessing pain in critically ill sedated patients using a behavioural pain scale. *Critical Care Medicine*, 29(12), 2258-2263.
- Pearce, J. (1988). The power of touch. *Nursing Times*, 84(24), 37-39.
- Pearcey, P. A. (1995). Achieving research-based nursing practice. *Journal of advanced nursing*, 22, 33-39.
- Pearson, A., Field, J., & Jordan, Z. (Eds.). (2007). *Evidence-based clinical practice in nursing and health care: assimilating research, experience and expertise*. Oxford: Blackwell Publishing.
- Peck, C. L. (1986). Psychological factors in acute pain management. In M. J. Cousins & G. D. Phillips (Eds.), *Acute Pain Management*. Melbourne: Churchill Livingstone.
- Pedersen, C. M., Rosendahl-Nielsen, M., Hjermand, J., & Egerod, I. (2009). Endotracheal suctioning of the adult intubated patient - What is the evidence? *Intensive and Critical Care Nursing*, 25(1), 21-30.
- Penfield, W. (1963). The physiological basis of the mind. In W. Penfield (Ed.), *The Second Career*.
- Penrod, J. (2007). Living with uncertainty: concept advancement. *Journal of advanced nursing*, 57(6), 658-667.

- Peric-Knowlton, W. (1984). The understanding and management of acute pain in adults: the nursing contribution. *International Journal of Nursing Studies*, 21(2), 131-143.
- Perry, S. (1985). Psychological reactions to pancuronium bromide. *American Journal of Psychiatry*, 142, 1390-1391.
- Phillips, G. D., & Cousins, M. J. (1986). Neurological mechanisms of pain and the relationship of pain, anxiety and sleep. In M. J. Cousins & G. D. Phillips (Eds.), *Acute Pain Management*. Melbourne: Churchill Livingstone.
- Pike, A. W. (1990). On the nature and place of empathy in clinical nursing practice. *Journal of Professional Nursing*, 6(4), 235-241.
- Pinkerton, S. (2003). Persuasion through the art of storytelling. *Nursing Economics*, 21(6), 298-299.
- Plato. (1892). *The Dialogues of Plato* (B. Jowett, Trans. 3rd ed. Vol. 1). Oxford: Oxford University Press.
- Plato. (1995). *Phaedrus* (A. W. Nehamas, Paul, Trans.). Indianapolis: Hackett Publishing Company.
- Plum, F., & Posner, J. (1980). *The diagnosis of stupor and coma*: FA Davis Company.
- Plummer, K. (1983). *Documents of life*. London: Allen & Unwin.
- Polanyi, L. (1985). Conversational Storytelling. In T. A. van Dijk (Ed.), *Discourse and Dialogue* (Vol. 3, pp. 183-201). London: Academic Press.
- Polanyi, M. (1962). *Personal knowledge: Towards a post-critical philosophy*. Chicago: University of Chicago Press.
- Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany: State University of New York Press.
- Powell, G. F., Brasel, J. A., & Blizzard, R. M. (1967). Emotional deprivation and growthretardation simulating idiopathic hypopituitarism. *New England Journal of Medicine*, 276, 1271-1276.
- Prescott, P. A., & Bowen, S. A. (1985). Physician/nurse relationships. *Annals of internal medicine*, 103, 127-133.
- Price, S. (1991). Student nurses and children's pain. *Nursing Standard*, 5(29), 25-28.
- Prkachin, K. M. (1997). The Consistency of Facial Expressions of Pain. In P. Ekman & E. L. Rosenberg (Eds.), *What the Face Reveals: Basic and Applied Studies of Spontaneous Expression Using the Facial Action Coding System (FACS)* (pp. 181-200). Oxford: Oxford Publishing Company.
- Puma, L., Schiedermayer, Gulyas, & Siegler. (1988). Talking to comatose patients. *Archives of Neurology*, 45, 20-22.
- Puntillo, K., Pasero, C., Li, D., Mularski, R. A., Grap, M. J., Erstad, B. L., et al. (2009). Evaluation of Pain in ICU patients. *Chest*, 135, 1069-1074.
- Puntillo, K. A. (1988). Pain and critical care. *Heart and Lung: Journal of Critical Care*, 17(3), 262-273.
- Puntillo, K. A. (1990). Pain experiences of intensive care unit patients. *Heart and Lung: Journal of Critical Care*, 19(5), 526-533.
- Puntillo, K. A., Morris, A. B., Thompson, C., Stanik-Hutt, J., White, C., & Wild, L. (2004). Pain behaviours observed during six common procedures: results from Thunder Project II. *Critical Care Medicine*, 32, 421-427.
- Pyles, S., & Stern, P. (1983). Discovery of nursing gestalt in critical care nursing. The importance of the gray gorilla syndrome. *IMAGE: Journal of Nursing Scholarship*, 15, 51-57.
- Rakow, L. F., & Wackwitz, L. A. (2004). Voice in Feminist Communication Theory. In L. F. Rakow & L. A. Wackwitz (Eds.), *Feminist communication theory: selections in context*. London: Sage.
- Ramos, M. C. (1992). The nurse-patient relationship: theme and variations. *Journal of advanced nursing*, 17, 496-506.

- Rankin, M. A., & Snider, B. (1984). Nurses' perception of cancer patients' pain. *Cancer Nursing*, 7(2), 149-155.
- Rather, M. (1992). "Nursing as a way of thinking" - Heideggerian hermeneutical analysis of the lived experience of the returning RN. *Research in Nursing and Health*(15), 47-55.
- Ray, M. A. (1985). A Philosophical Method to Study Nursing Phenomena. In M. M. Leininger (Ed.), *Qualitative Research Methods in Nursing* (pp. 81-92). Orlando: Grune & Stratton.
- Reason, P., & Hawkins, P. (1988). Storytelling as Inquiry. In P. Reason (Ed.), *Human Inquiry in Action - Developments in New Paradigm Research* (pp. 79-101). London: Sage Publications.
- Regan, M., & Liaschenko, J. (2008). In the Margins of the Mind: Development of a Projective Research Methodology for the Study of Nursing Practice. *Research and Theory for Nursing Practice*, 22(1), 10-23.
- Reilly, F. E. (1993). Experiences of family among homeless individuals. *Issues in Mental Health Nursing*, 14, 309-321.
- Reimen, D. J. (1986). Noncaring and caring in the clinical setting: patients' descriptions. *Topics in Clinical Nursing*, 8(2), 30-36.
- Reinharz, S. (1984). *On Becoming a Social Scientist: From Survey Research and Participant Observation to Experiential Analysis*. New Brunswick, NJ: Transaction Books.
- Reutter, L. I., & Northcott, H. C. (1994). Achieving a sense of control in the context of uncertainty: Nurses and AIDS. *Qualitative Health Research*, 4(1), 51-71.
- Reverby, s. (1987). A caring dilemma: Womanhood and nursing in historical perspective. *Nursing Research*, 36, 5-11.
- Reverby, S. (1987). *Ordered to care: The dilemma of American nursing 1850-1945*. Cambridge: Cambridge University Press.
- Rew, L. (1986). Intuition: concept analysis of a group phenomenon. *Advances in nursing science*, 8(2), 21-28.
- Rew, L. (1988). Intuition in decision-making. *IMAGE: Journal of Nursing Scholarship*, 20(3), 150-155.
- Rew, L., & Barrow, E. M. (1987). Intuition: a neglected hallmark of nursing knowledge. *Advances in nursing science*, 10(1), 49-62.
- Rhiannon. (1992). The miracle of life. *Nursing in Focus: The Royal Melbourne Hospital*, 1.
- Richards, I. (1936). *The Philosophy of Rhetoric*. London: Oxford University Press.
- Richards, K. C. (1994). Sleep promotion in the critical care unit. *AACN Clinical Issues in Critical Care Nursing*, 5(2), 152-158.
- Richards, T. A., & Folkman, S. (2000). Response shift: A coping perspective. In C. E. Schwartz, M. A. G. Sprangers & e. al (Eds.), *Adaptation to changing health: Response shift in quality-of-life research* (pp. 25-36). Washington DC US: American Psychological Association.
- Richardson, L. (1985). *The New Other Woman: Contemporary Women in Affairs with Married Men*. New York: Free Press.
- Richardson, L. (1988). The collective story: Postmodernism and the writing of sociology. *Sociological Focus*, 21(3), 199-208.
- Richardson, L. (1990). Narrative and sociology. *Journal of Contemporary Ethnography*, 19(1), 116-135.
- Ricoeur, P. (1966). *Freedom and nature: the voluntary and the involuntary* (E. V. Kohak, Trans.). Evanston, Illinois: Northwestern University Press.
- Ricoeur, P. (1976). *Interpretation Theory: Discourse and the Surplus of Meaning* (6th ed.). Texas: Texas Christian University Press.
- Ricoeur, P. (1978). *The Rule of Metaphor: Multi-Disciplinary Studies in the Creation of Meaning in Language* (R. Czerny, K. McLaughlin & J. Costello, Trans.). London: Routledge and Kegan Paul.

- Ricoeur, P. (1979). The human experience of time and narrative. *Research in Phenomenology*, 9, 24.
- Ricoeur, P. (1980). Toward a hermeneutic of the idea of Revelation. In L. S. Mudge (Ed.), *Essays on Biblical Interpretation*. London: SPCK.
- Ricoeur, P. (1981). *Hermeneutics and the human sciences*. Cambridge: Cambridge University Press.
- Ricoeur, P. (1984). The model of text: meaningful action considered as text. *Social Research*, 51, 185-218.
- Ricoeur, P. (1986). *Time and Narrative* (K. M. a. D. Pellauer, Trans. Vol. 2). Chicago: The University of Chicago Press.
- Ricoeur, P. (1990). *Time and Narrative* (K. M. Kathleen Blamey, David Pellauer, Trans. Vol. 1). Chicago: University of Chicago Press.
- Riehl-Sisca, J. P. (Ed.). (1989). *Conceptual models for nursing practice*. Norwalk CT: Appleton & Lange.
- Riessman, C. K. (1989a). From victim to survivor: a woman's narrative reconstruction of marital abuse. *Smith College Studies in Social Work*, 59, 232-251.
- Riessman, C. K. (1989b). Life events, meaning and narrative: the case of infidelity and divorce. *Social Science and Medicine*, 29(6), 743-751.
- Riessman, C. K. (1990). Strategic uses of narrative in the presentation of self and illness: a research note. *Social Science and Medicine*, 30(11), 1195-1200.
- Riessman, C. K. (1993). *Narrative Analysis* (Vol. 30). Newbury Park: Sage.
- Robbins, A. (2004). *Six Human Needs*. Paper presented at the Unleash the Power Within, Sydney.
- Roberts, B. L., Rickard, C. M., Rajbhandari, D., & Reynolds, P. (2007). Factual memories of ICU: recall at two years post-discharge and comparison with delirium status during ICU admission - a multicentre cohort study. *Journal of Clinical Nursing*, 16(9), 1669-1677.
- Robinson, C. A. (1993). Managing life with a chronic condition: The story of normalization. *Qualitative Health Research*, 3(1), 6-28.
- Robinson, I. (1990). Personal narratives, social careers and medical courses: analysing life trajectories in autobiographies of people with multiple sclerosis. *Social Science and Medicine*, 30(11), 1173-1186.
- Robinson, J. A., & Hawpe, L. (1986). Narrative thinking as a heuristic process. In T. R. Sarbin (Ed.), *Narrative Psychology*. New York: Praeger.
- Robinson, J. A., & Lewis, D. J. (1987). Coping with ICU work-related stressors: a study. *Critical Care Nurse*, 10(5), 80-88.
- Roper, N., Logan, W. W., & Tierney, A. J. (1980). *The Elements of Nursing*. Edinburgh: Churchill Livingstone.
- Rorty, R. (1979). *Philosophy and the mirror of nature*. Princetown: Princetown University Press.
- Rotter, J. (1966). Generalized expectancies for internal versus external control of reinforcements. *Psychological Monographs*, 80(609).
- Rowe, M. (2003). The Structure of the Situation: A Narrative on High-Intensity Medical Care. *Hastings Centre Report*, 33(6), 37-44.
- Roy, C. (1984). *Introduction to Nursing: an adaptation model*. New Jersey: Prentice Hall.
- Ruiz, P. A. (1993). The needs of a patient in severe status asthmaticus: experiences of a nurse- patient in an intensive care unit. *Intensive and Critical Care Nursing*, 9, 28-39.
- Rushton, C. H. (1991). Humanism in critical care: a blueprint for change. *Pediatric Nursing*, 17(4), 399-402.
- Ruth-Sahd, L. A. (2003). Reflective practice: A critical analysis of data-based studies and implications for nursing education. *Journal of Nursing Education*, 42(11), 488-497.

- Rycroft-Malone, J., Harvey, G., Seers, K., Kitson, A., McCormack, B., & Titchen, A. (2004). An exploration of the factors that influence the implementation of evidence into practice. *Journal of Clinical Nursing, 13*, 913-924.
- Rycroft-Malone, J., Seers, K., Titchen, A., Harvey, G., Kitson, A., & McCormack, B. (2004). What counts as evidence in evidence-based practice? *Journal of advanced nursing, 47*(1), 81-90.
- Sacks, H. (1986). Some considerations of a story told in ordinary conversation. *Poetics, 15*, 127-138.
- Sakalys, J. A. (2006). Bringing bodies back in. *International Journal for Human Caring, 10*(3), 17-21.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in nursing science, 8*(3), 27-37.
- Sandelowski, M. (1991). Telling stories: Narrative approaches in qualitative research. *IMAGE: Journal of Nursing Scholarship, 23*(3), 161-166.
- Sarbin, T. R. (1986). The narrative as a root metaphor for psychology. In T. R. Sarbin (Ed.), *Narrative Psychology: The Storied Nature of Human Conduct* (pp. 3-21). New York: Praeger.
- Savoley, P., Smith, A. F., Turk, D. C., Jobe, J. B., & Willis, G. B. (1993). The accuracy of memory for pain. *American Pain Society Journal, 2*, 184-191.
- Schapp, W. (1976). In *Geschichten Verstrickt (Entangled in Stories)* (B. Heymann, Trans. 2nd ed.). Wiesbaden.
- Scheibe, K. E. (1986). Self-narratives and adventure. In T. R. Sarbin (Ed.), *Narrative Psychology*. New York: Praeger.
- Schmidt, M. H. (1977). The nature of pain, with some personal notes. *Nursing Clinics of North America, 12*(4), 621-629.
- Schnaper, N. (1975). The psychological implications of severe trauma: emotional sequelae to unconsciousness. *Journal of Trauma, 15*(2), 94-98.
- Scholes, R., & Kellogg, R. (1966). *The Nature of Narrative*. New York: Oxford University Press.
- Schon, D. A. (1983). *The reflective practitioner: how professionals think in action*. Aldershot: Arena.
- Schrier, R. W. (2006). *Diseases of the kidney and urinary tract: Clinicopathologic Foundations of Medicine* (8th ed. Vol. 1). Philadelphia: Lippincott Williams and Wilkins.
- Schultz, P. R. (1987). Toward a holistic inquiry in nursing: a proposal for synthesis of patterns and methods. In S. R. Gortner (Ed.), *Nursing Science Methods: A Reader* (pp. 17-29). San Francisco: Regents.
- Schuman, A. (1986). *Storytelling Rights: the uses of oral and written texts by urban adolescents*. Cambridge: Cambridge University Press.
- Schuman, H., & Presser, S. (1981). *Questions and Answers in Attitude Surveys: Experiments on Question Form, Wording and Content*. New York: Academic Press.
- Sheen, L., & Oates, J. (2005). A phenomenological study of medically induced unconsciousness in intensive care. *Australian Critical Care, 18*(1), 25-32.
- Sheredy, C. (1984). Factors to consider when assessing responses to pain. *The American Journal of Maternal Child Nursing, 9*(4), 250-252.
- Sherrington, C. (1953). *Man on His Nature*.
- Shuldham, C. (1984). Communication - a conscious effort. *Nursing (Add-On Series), 2*(23), 673-675.
- Sibbald, R., Downer, J., & Hawryluck, L. (2007). Perceptions of "futile care" among caregivers in intensive care units. *Canadian Medical Association Journal, 177*(10), 1201-1208.
- Siffleet, J., Young, J., Nikoletti, S., & Shaw, T. (2007). Patients' self-report of procedural pain. *Journal of Clinical Nursing, 16*(11), 2142-2148.

- Silverman, D. (1985). *Qualitative methodology and sociology*. Aldershot: Gower.
- Simpson, T. F., Armstrong, S., & Mitchell, P. (1989). American Association of Critical Care Nurses demonstration project: patient's recollections of critical care. *Heart and Lung: Journal of Critical Care*, 18(4), 325-332.
- Sims, S. (1986). Slow stroke back massage for cancer patients. *Nursing Times*, 82(13), 47-50.
- Slack, J. F., & Faut-Callahan, M. (1991). Efficacy of epidural analgesia for pain management of critically ill patients and the implications for nursing care. *AACN Clinical Issues in Critical Care Nursing*, 2(4), 729-740.
- Smeltzer, C. H., & Vlasses, F. (2004). Storytelling: A tool for leadership to shape culture...listen to nurses' stories. *Journal of Nursing Care Quarterly*, 19(1), 74-75.
- Smith, B. H. (1980). Narrative versions, narrative theories. *Critical Inquiry*, 7, 212-236.
- Smith, D. E. (1983). No one commits suicide: textual analysis of ideological practices. *Human Studies*, 6, 309-359.
- Smith, G. (2006). Telling tales - hos stories and narratives co-create change, *The Casson Memorial Lecture 2006* (Vol. 69). 30th Annual Conference of the College of Occupational Therapists held at Cardiff International Arena, Cardiff, Wales: British Journal of Occupational Therapy.
- Smith, W. B., & Safer, M. A. (1993). Effects of present pain level on recall of chronic pain and medication use. *Pain*, 55, 355-361.
- Soderberg, A., & Norberg, A. (1993). Intensive care: situations of ethical difficulty. *Journal of advanced nursing*, 18, 2008-2014.
- Soderstrom, I. M., Benzein, E., & Saveman, B. I. (2003). Nurses' experiences of interactions with family members in intensive care units. *Scandinavian Journal of Caring Sciences*, 17(2), 185-192.
- Solomon, H. (1994). The transcendent function and Hegel's dialectical vision. *Journal of Analytical Psychology*, 39, 77-100.
- Solomon, R. C., & Higgins, K. M. (1996). *A Short History of Philosophy*. New York: Oxford University Press.
- Sorrentino, R. M., & Roney, C. J. R. (2000). *The uncertain mind: individual differences in facing the unknown*. Philadelphia PA US: Psychology Press/Taylor & Francis.
- Speedy, S. (1990, July 11-13). *Never mind the width, feel the quality*. Paper presented at the Dreams, Deliberations & Discoveries: Nursing Research in Action, Adelaide Convention Centre.
- Stahl, S. K. D. (1983). Studying Folklore and American Literature. In R. M. Dorson (Ed.), *Handbook of American Folklore* (pp. 422-433). Bloomington: Indiana University Press.
- Stanton, D. J. (1991). The psychological impact of intensive therapy: the role of the nurse. *Intensive Care Nursing*, 7(4), 230-235.
- Stein, L. I. (1967). The doctor-nurse game. *Archives of General Psychiatry*, 16, 699-703.
- Stein, L. I., Watts, D. T., & Howell, T. (1990). The doctor-nurse game revisited. *New England Journal of Medicine*, 322, 546-549.
- Steiner, G. (1978). *Heidegger*. London: Fontana Press.
- Stein-Parbury, J. (1999). *Through the Fog: Nursing care of Patients who are Confused while in ICU*. University of Adelaide, Adelaide.
- Stein-Parbury, J., & Liaschenko, J. (2007). Understanding collaboration between nurses and physicians as knowledge at work. *American Journal of Critical Care*, 16, 470-477.
- Stevens, P. E. (1989). A critical social reconceptualization of environment in nursing: implications for methodology. *Advances in nursing science*, 11(4), 56-68.
- Stevens, P. E. (1993). Marginalized women's access to health care: A feminist narrative analysis. *Advances in nursing science*, 16(2), 39-56.

- Stevens, P. E. (1994). Protective strategies of lesbian clients in health care environments. *Research in Nursing and Health, 17*, 217-229.
- Stewart, M. L. (1977). Measurement of clinical pain. In A. K. Jacox (Ed.), *Pain: A source book for nurses and other health professionals* (pp. 107-137). Boston: Little, Brown & Co.
- Stilos, K., Maoura, S. L., & Flint, F. (2007). Building comfort with ambiguity in nursing practice. *Clinical Journal of Oncology Nursing, 11*(2), 259-263.
- Stone, J. (1965). *Human land and human justice*. Stanford: Stanford University Press.
- Storli, S., Lindseth, A., & Asplund, K. (2008). A journey in quest of meaning: a hermeneutic-phenomenological study on living with memories from intensive care. *Nursing in Critical Care, 13*(2), 86-96.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research*. Newbury Park: Sage.
- Styles, M. M. (1982). *On nursing toward a new endowment*. St Louis: C.V. Mosby.
- Swanson, J. M., Albright, J., Steirn, C., Schaffner, A., & Costa, L. (1992). Program efforts for creating a research environment in a clinical setting. *Western Journal of Nursing Research, 14*(2), 241-245.
- Sweet, S. J., & Norman, I. J. (1995). The nurse-doctor relationship: a selective literature review. *Journal of advanced nursing, 22*, 165-170.
- Tabak, N., Bar-Tal, Y., & Cohen-Mansfield, J. (1996). Clinical decision-making of experienced and novice nurses. *Western Journal of Nursing Research, 18*, 534-548.
- Tanner, C. (1987). Teaching clinical judgement. In J. Fitzpatrick & R. Taunton (Eds.), *Annual review of nursing research* (Vol. 5, pp. 153-173). New York: Wiley.
- Tanner, C. A., Benner, P., Chelsa, C., & Gordon, D. (1993). The phenomenology of knowing a patient. *IMAGE: Journal of Nursing Scholarship, 25*(4), 273-280.
- Tanner, C. A., Padrick, K. P., Westfall, U. E., & Putzier, D. J. (1987). Diagnostic reasoning strategies of nurses and nursing students. *Nursing Research, 36*(6), 358-363.
- Tappan, M. B. (1989). Stories lived and stories told: The narrative structure of late adolescent moral development. *Human Development, 32*, 300-315.
- Tappan, M. B. (1990). Hermeneutics and moral development: Interpreting narrative representations of moral experience. *Developmental Review, 10*, 239-265.
- Taylor, B. (1993). Phenomenology: one way to understand nursing practice. *International Journal of Nursing Studies, 30*(2), 171-179.
- Taylor, B. (1995). Nursing as healing work. *Contemporary Nurse, 4*, 100-106.
- Taylor, B. J. (1992). From helper to human: a reconceptualization of the nurse as person. *Journal of advanced nursing, 17*, 1042-1049.
- Taylor, B. J. (1993). Caring: Being Manifested as Ordinariness in Nursing. In D. A. Gaut (Ed.), *A global agenda for caring* (pp. 181-200). New York: National League for Nurses.
- Teasdale, G., & Jennett, B. (1974). Assessment of coma and impaired consciousness. A practical scale. *The Lancet, 2*(7872), 81-84.
- Teske, K., Daut, R. L., & Cleeland, C. S. (1983). Relationship between nurses' observations and patients self-reports of pain. *Pain, 16*(3), 289-296.
- Thompson, C., & Dowding, D. (2001). Responding to uncertainty in nursing practice. *International Journal of Nursing Practice, 5*, 609-615.
- Thorpe, D. M. (1989). Pain assessment: I. Matching the tool to the patient needs. *Dimensions in Oncology Nursing, 3*(2), 19-25.
- Tibbles, L., & Sanford, R. (1994). The research journal club: a mechanism for research utilization. *Clinical Nurse Specialist, 8*(1), 23-26.
- Tiernan, P. J. (1994). Independent nursing interventions: Relaxation and guided imagery in critical care. *Critical Care Nurse, 47*-51.
- Titler, M. G., Kleiber, C., Steelman, V., Goode, C., Rakel, B., Barry-Walker, J., et al. (1994). Infusing research into practice to promote quality care. *Nursing Research, 43*(5), 307-313.

- Toomy, T. C., Mann, J. D., Abachian, S., & Thompson-Pope, S. (1991). Relationship between perceived self-control of pain, pain description and functioning. *Pain, 45*(2), 129-133.
- Tosch, P. (1988). Patients' recollections of their posttraumatic coma. *Journal of Neuroscience Nursing, 20*(4), 223-228.
- Tresch, D. D., Sims, F. H., Duthie, E. H., & Goldstein, M. D. (1991). Patients in a persistent vegetative state: Attitudes and reactions of family members. *Journal of the American Geriatrics Society, 39*, 17-21.
- Tuffnell, C., & Clark, S. (1988). Post-operative pain: a trial of a pain assessment tool. *Nursing Praxis in New Zealand, 4*(1), 19-23.
- Turner, J. S., Briggs, S. J., Springhorn, H. E., & al., e. (1990). Patients' recollection of intensive care unit experience. *Critical Care Medicine, 18*, 966-968.
- Turnock, C. (1989). A study into the views of intensive care nurse on the psychological needs of their patients. *Intensive Care Nursing, 5*, 159-166.
- Twigg, R. C. (1994). The unknown soldiers of foster care: foster care as loss for the foster parents' own children. *Smith College Studies in Social Work, 64*(3), 297-312.
- Tyler, D., Winslow, E., Clark, A., & White, K. (1990). Effects of a 1 minute back rub on mixed venous oxygen saturation and heart rate in critically ill patients. *Heart and Lung: Journal of Critical Care, 19*(5), 562-565.
- Uden, G., Norberg, A., Lindseth, A., & Marhaug, V. (1992). Ethical reasoning in nurses' and physicians' stories about care episodes. *Journal of advanced nursing, 17*, 1028-1034.
- Usher, R., & Bryant, I. (1989). *Adult education as theory, practice and research: the captive triangle*. London: Routledge.
- van Hooff, S. M. (1987). Caring and professional commitment. *The Australian Journal of Advanced Nursing, 4*(4), 29-38.
- Van Maanen, J. (1988). *Tales of the field: On writing ethnography*. Chicago: University of Chicago Press.
- Van Manen, M. (1990). *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. New York: State University of New York Press.
- VanDalfsen, P. J., & Syrjala, K. L. (1990). Psychological strategies in acute pain management. *Critical Care Clinics, 6*(2), 421-431.
- Varcoe, C., Doane, G., Pauly, B., Rodney, P., Storch, J., Mahoney, K., et al. (2004). Ethical practice in nursing: working the in-betweens. *Journal of advanced nursing, 45*(3), 316-325.
- Viney, L. L., & Bousfield, L. (1991). Narrative analysis: A method of psychosocial research for AIDS-affected people. *Social Science and Medicine, 32*(7), 757-765.
- Vitz, P. C. (1990). The use of stories in moral development: New psychological reasons for an old education method. *American Psychologist, 45*(6), 709-720.
- von Franz, M.-L. (1982). *An introduction to the interpretation of fairytales*. Dallas: Spring Publishing Company.
- Vratny, A., & Shriver, D. (2007). A conceptual model for growing evidence-based practice. *Nursing Administration Quarterly, 31*(2), 162-170.
- Walding, M. F. (1991). Pain, anxiety and powerlessness. *Journal of advanced nursing, 16*(4), 388-397.
- Waldman, C. S., Tseng, P., Meulman, P., & Whittet, H., B. (1993). Aromatherapy in the intensive care unit. *Care of the Critically Ill, 9*(4), 170-174.
- Walker, J. M., & Campbell, S. M. (1989). Pain assessment, nursing models and the nursing process. *Recent Advances in Nursing*(24), 47-61.
- Walker, P. H., & Neuman, B. M. (1995). *Blueprint for use of nursing models: Education, Research, Practice and Administration*. U.S.: National League for Nursing.
- Wall, P. D. (1978). The Gate Control Theory of Pain Mechanisms: A Re-examination and Re-statement. *Brain, 101*, 1-18.

- Walters, A. J. (1992). *The phenomenon of caring in an intensive care unit*. Deakin University, Geelong, Victoria, Australia.
- Walters, A. J. (1994). The comforting role in critical care nursing practice: A phenomenological interpretation. *International Journal of Nursing Studies*, 31(6), 607-616.
- Walters, A. J. (1995). A Heideggerian hermeneutic study of the practice of critical care nurses. *Journal of advanced nursing*, 21, 492-497.
- Watson, C. (1987). Portrait study. *Nursing Times*, 83(25), 64-67.
- Watts, R. (1993). Caring: beyond the dyad. In D. A. Gaut (Ed.), *A Global Agenda for Caring* (pp. 141-153). New York: National League for Nursing Press.
- Watt-Wattson, J. H. (1987). Nurses' knowledge of pain issues: a survey. *Journal of Pain and Symptom Management*, 2, 207-211.
- Webb, C., & Hope, K. (1995). What kind of nurses do patients want? *Journal of Clinical Nursing*, 4, 101-108.
- Weber, D. (2005). How do you gauge the skill levels of your nurses: start with a story. *Patient Care Staffing Reports*, 5, 1-71.
- Webster, M. (2009). Merriam Webster Online Dictionary.
- Weddell, G., Sinclair, D. C., & Feindel, W. H. (1948). An anatomical basis for alterations in quality of pain sensibility. *Journal of Neurophysiology*, 11, 99-109.
- Weedon, C. (1987). *Feminist practice and poststructuralist theory*. Oxford: Basil Blackwell.
- Wegman, D. (2005). Tool for pain assessment [letter]. *Critical Care Nurse*, 25(1), 14-15.
- Weisenburg, M. (1989). Cognitive aspects of pain. In P. D. Wall & R. Melzack (Eds.), *Textbook of pain* (2nd ed.). Edinburgh: Churchill Livingstone.
- Weiss, S. J., & Remen, N. (1983). Self-limiting patterns of nursing behaviour within a tripartite context involving consumers and physicians. *Western Journal of Nursing Research*, 5, 77-89.
- Weissman, D. E. (2000). Doctors, Nurses, and Storytelling. *Journal of Palliative Medicine*, 3(3), 251-252.
- West, A. F., & West, R. R. (2002). Clinical decision-making: coping with uncertainty. *Postgraduate Medicine*, 78, 319-321.
- White, D., & Tonkin, J. (1991). Registered nurse stress in intensive care units - an Australian perspective. *Intensive Care Nursing*, 7, 45-52.
- White, H. (1980). The value of narrativity in the representation of reality. *Critical Inquiry*, 7, 5-27.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.
- White, S. K. (1989). Bringing out the best in all of us. *Heart and Lung: Journal of Critical Care*, 18(6), 27a-30a.
- Wild, L. (1990). Pain Management. *Critical Care Nursing Clinics of North America*, 2(4), 537-547.
- Wilensky, R. (1983). Story grammars versus story points [with commentaries]. *Behavioural and Brain Sciences*, 6, 579-623.
- Wilkin, K., & Slevin, E. (2004). The meaning of caring to nurses: an investigation into the nature of caring work in an intensive care. *Issues in Clinical Nursing*, 13, 50-59.
- Williams, G. H. (1989). Hope for the humblest? The role of self-help in chronic illness: the case of ankylosing spondylitis. *Sociology of health and illness*, 11, 135-159.
- Wilson, H. S. (1990). *Reaching for Relevance in Clinical Nursing Research*. Keynote address., University of California, San Francisco.
- Wilson, V. S. (1987). Identification of stressors related to patients' psychological responses to the surgical intensive care unit. *Heart and Lung: Journal of Critical Care*, 16(3), 267-273.

References

- Wilson-Barnett, J., Corner, J., & De Carle, B. (1990). Integrating nursing research and practice - the role of the researcher as teacher. *Journal of advanced nursing*, 15, 621-625.
- Winter, R. (1989). *Learning from experience: principles and practice in action research*. Lewes: Falmer Press.
- Wolfson, N. (1978). A feature of performed narrative: the conversational historical present. *Language in Society*, 1, 215-237.
- Wong, J., Wong, S., & Demdster, I. K. (1984). Care of the unconscious patient: A problem-orientated approach. *Journal of Neurosurgical Nursing*, 16(3), 145-150.
- Wood, C. A., Bailey, L. R., & Yates, J. W. (1982). Advanced cancer pain management in a community setting. *Oncology Nursing Forum*, 9, 32-36.
- Wood, C. A., & Dodge, R. K. (1982). Continuing educational goals and learning needs of community care nurses who care for patients with cancer. *Journal of Continuing Education in Nursing*, 13, 14-18.
- Woodrow, P., & Roe, J. (2000). *Intensive Care Nursing: A Framework for Practice*. London: Routledge.
- Woolley, N. (1990). Crisis theory: a paradigm of effective intervention with families of critically ill people. *Journal of advanced nursing*, 15, 1402-1408.
- Wright, J., & Morley, S. (1995). Autobiographical memory and chronic pain. *British Journal of Clinical Psychology*, 34, 255-265.
- Wyatt, C., & Wyatt, J. (1994). Shall we play 'doctors and nurses'? Problems in nurse-doctor relationships. *Christian Nurse International*, 10(4), 8-9.
- Young, K. (1987). *Taleworlds and Storyrealms* (Vol. 16). Netherlands: Martinus Nijhoff Publishers.
- Zalumas, J. (1995). *Caring in Crisis: an oral history of critical care nursing*. USA: Library of Congress.
- Zimbardo, P. G. (1985). *Psychology and life* (11th ed.). Glenview Ill: Scott, Foresman.